CHAPTER ONE: INTRODUCTION

This study arises out of general trends in thought pertaining to the evolution of psychoanalysis in the context of post-apartheid South Africa. The applicability of psychoanalysis in this context is a contentious issue, highlighted at the psychoanalytic Trust Conference held in Cape Town, March 1998. At this meeting several questions were raised about the relevancy of psychoanalytic theory in the context of South Africa's traumatised communities. This conference was a watershed: it signified a turning point in the evolution of thought on the development of psychoanalysis in a new South Africa. Not only did it provide a foundation for debate on the professional training of psychologists but it also encouraged practicing clinicians to be critical of the value systems and theoretical assumptions they were using when interpreting and understanding issues of a cross-cultural nature (Swartz, S., 1998)[1]. This conference concluded by raising the concern that whilst standard psychoanalytic theory may be relevant to a western-based White minority, its applicability to the broader community of a new South Africa is questionable and remains largely unresearched.

In September 2002 the Psychological Association of South Africa (PSYSSA) held its 8th annual meeting at the University of the Western Cape. Similar themes emerged from this meeting with discussion focusing largely on ways of making psychological services more available to poor and rural communities. It was strongly felt that the general perception of psychology needed to be broadened beyond "the couch": the couch - and by implication, psychoanalysis - was an inappropriate tool for helping the previously disadvantaged deal with their problems (*Cape Times* article 26/09/02). However, it was concluded that psychology has a role to play in the healing of all people in the developing world and should not be confined exclusively to the "middle class".

Psychoanalytic psychotherapy is a form of therapy that is based on understandings drawn from classical psychoanalysis. This form of psychotherapy relies on making conscious those processes that are unconscious. It adheres to certain principles of practice that must necessarily be followed in order for unconscious processes to be made manifest. These principles are enacted within a specific therapeutic frame of working and are embodied in the concept of the **analytic attitude**, which is central to the practice of psychoanalytic psychotherapy.

The analytic attitude refers to a professional mindset involving five principles: *generative uncertainty*, *abstinence*, *neutrality*, *countertransference receptivity*, *resoluteness*; and three inter-

[1] The format of this dissertation follows the guidelines laid down in the publication manual of the *American Psychological Association*

related concepts: *the analytic task, the analytic process* and *the analytic setting* (Ivey, 1999, p. 6). These principles underlie the practice of all therapeutic approaches that adhere to the concept of the human unconscious. Various depth psychology philosophies may disagree on the level of theoretical and technical issues but all these divisions practise the analytic attitude (ibid). More specifically this attitude refers to a "deeply rooted, coherent, professional mind-set that incorporates philosophical, ideological, psychological and ethical concerns" (Ivey, 1999, p. 3). It defines the psychoanalytic practitioner in terms of what he[2] knows, what he believes and how he should conduct himself in the therapeutic setting (ibid).

Within a western framework of practice psychoanalysis is widely accepted as an effective form of treatment for individuals with psychological difficulty, especially those who are neurotic and are encumbered in daily living by the intensity of childhood desires that cause them repeatedly to recreate in their current relationships the distressing scenarios experienced in early childhood. However, whilst it is well recognised that this model of understanding represents a sophisticated treatment approach, it must also be acknowledged that the basic conceptual framework of psychoanalytic psychotherapy is born out of western notions of subject-object duality and is therefore not directly transportable to those cultures that are based on collective notions of subject-object unity. Psychoanalytic psychotherapy and its corollary the analytic attitude has evolved out of and is strongly attached to western values and beliefs about self-determination and individualism. Furthermore, psychoanalytic psychotherapy has been devised and implemented in accordance with western assumptions about psychological health and development.

To expect that specific theoretical assumptions can be transported in their current form and be effective to Black South Africans is optimistic because the cultural patternings are different. For instance the Oedipus complex, which is central to the psychoanalytic thought established by Freud, arose at a time when the cultural patternings of authority in the family and in society were strongly paternalistic. Whilst it is well established that the oedipal struggle is a universal phenomenon (Abel, 1987), it is also recognised that variations on this framework occur depending on the cultural patterns of approved behaviour inculcated by parents and society at any given historical period. The "Parent" in many African families may be a parent surrogate or a series of parent displacements, thus giving rise to unpredictable manifestations of castration anxiety and the oedipal struggle.

[2] To assist the flow of text throughout this thesis "he", "him" and "his" etc will be understood as referring to "she", "her" and "hers" etc and vice versa.

Similarly it is reasonable to expect that certain elements of the analytic attitude and the way in which it is implemented will need to be re-thought. Individuals from traditional collective communities who seek treatment for psychological concerns are more orientated to accepting a directive and authoritarian model of treatment. Such an expectation does not fit well into the analytic attitude, which deliberately withholds suggestion and direction. The analytic attitude, which is based on the values of the western individualistic self, is more likely to call upon individuals to introspect, self-reflect and to locate the source of their psychological concerns in themselves. This way of thinking about psychological difficulties as being located primarily within rather than without may be unfamiliar to individuals who still adhere to a collective cosmology that sees symptoms as being caused by external agents such as curses, bewitchment and ancestors.

This study does not support the perception that practice of psychoanalytic theory is irrelevant to a new and developing South Africa. On the contrary it supports the view that psychoanalytic theory provides a sophisticated system of understanding for those unconscious processes that form a part of all human personality - regardless of race and culture (Schlebusch, 1998). It recognizes that psychoanalysis is a valid model for treating and alleviating distressing symptoms in people's lives deriving from unconscious motivations. However, this study also acknowledges that practice of psychoanalytic psychotherapy in South Africa has been largely confined to a western minority group.

Historically the concept of the individualised self and its derived treatment modalities has been elevated to represent an ideal standard against which all cultures are judged and treatment provided. This universal approach has given rise to many misunderstandings and it is now generally accepted that whilst certain elements of psychoanalytic theory may hold true across culture, the differences need to be acknowledged by adopting a relativist approach that allows for such concepts to be de-contextualised from their western framework and then re-contextualised in terms of the unique nature of the culture to which it is being applied.

In order for psychoanalytic psychotherapy to move beyond its current field of practice certain elements of theory and practice need to be modified. If this framework of "thinking about" and "treating" individuals is to be effective then it needs to adjust to the specific cross-cultural patterns of a non-western population. Current understandings concerning the implementation of individual psychoanalytic psychotherapy on the level of both practice and theory are not necessarily irrelevant but will need to be revised if this model of working with and thinking about people cross-culturally is to carry credibility and be further developed in South Africa.

A person's sense of self is inextricably linked to his definition of himself through cultural values and ideals that are inseparable from his psychological processes. Culture informs the configuration of the self. All approaches for treatment and healing flow out of and reflect culturally determined conceptualisations of self. Just as the traditional healing practices of Black South African culture reflect the collective self so does psychoanalytic theory and practice in its present form reflect the concept of the western individualised self. The ability to be consciously aware of and describe subjective experience, thoughts, feelings and opinions serves little purpose and carries little value in traditional communities. Individuals are not encouraged to self-reflect, that is not to say that they are unable to do so but rather that traditional structures of expression have not required them to develop these resources (Ulmer, 2003). If effective treatment approaches can be seen as logical extensions of cultural configurations of self then it follows that psychoanalytic theory in its western dualistic form cannot be readily applicable to those traditional cultures in which dualisms are absent and little or no emphasis is placed on the individual.

The socio-economic and past political conditions in South Africa have caused much fragmentation of social and familial structures. This has given rise to much violence, poverty, unemployment and dehumanisation. The vast majority of individuals in South Africa are in a process of transition and new identity formation. Many South Africans straddle two worlds: a rural to urban shift, a traditional to western viewpoint, and a collective identity to an individual identity (Donald, Dawes & Louw, 2000). There is an emerging group of Black South Africans educated through a western system who represent a conglomerate or hybridisation of the collective self and the individualised self. This sense of self is at once different from and similar to its polar opposites of the individual and collective and in this study is referred to as the "expanding self" (Roland, 1988, p. 6). Members of this group aspire to the ideals of individualism but also maintain strong elements of the collective self into which they were born. The effect of this transition on the individual is profound and often causes much distress. With the breakdown of traditional structures of support individuals require new support structures, which are presently lacking.

As South Africa society continues to develop in accordance with the western ideals of individualism, as encapsulated in the constitution and the bill of rights, so more and more people are adopting the values of western culture. Economic policy, health care, legal and judicial and educational systems all promote the rights of the individual (Donald et al., 2000). It seems clear that as these values become more entrenched so the need for appropriate models of psychological treatment will increase. These models will have to be tailored to the specific needs of an

emerging class of individuals who embody both collective values and western values simultaneously. Traditional healing approaches do not adequately meet the needs of this emerging group as most of its members are aspiring towards western ideals. Similarly western psychoanalysis in its present form is also inadequate in so far as it is unable to accommodate the inherent collective element of this group. An adapted form of treatment needs to be devised for this group that is able to incorporate both collective and individual elements.

By examining the evolution of psychoanalytic thought from its historical foundations towards more contemporary developments it is clear that both theory and practice of psychoanalytic treatment are flexible and able to accommodate the changing needs of society. Psychoanalytic theory and practice is not a fixed entity but rather is in a state of flux and continues to be revised in the light of new developments in analytic experience and changing social conditions. Cross-cultural psychotherapy is now a part of everyday practice in many western countries and the practice of psychoanalysis is beginning to reflect this transformation (Kadyrov, 2002). Whilst such historical changes have been significant, they have been largely confined to the changing needs of different western cultural groups. Adaptations to non-western cultural groups have moved more slowly (Kadyrov, 2002). This study contends that if psychoanalytic theory and practice has always been in a state of change then it is reasonable to suggest that this treatment modality can be amended to meet the specific needs of an emerging class of Black South Africans who are showing an increasing interest in this form of treatment.

Arising out of the concerns raised above, the main objective of this research study is to explore the applicability of individual psychoanalytic psychotherapy to Black second-language English-speaking individuals in the Urban Cape peninsula, and if necessary to make recommendations for theoretical and technical adaptations to the analytic attitude. It must be noted that while psychoanalysis has been a frequent subject of research literature in South Africa, little research has been done specifically on the conceptual and practical aspects of the analytic attitude and on the reformulation of basic psychoanalytic principles to meet the needs of Black South Africans in individual psychotherapy.

In order to establish the applicability of the analytic attitude it was useful to explore it in practice. By critically examining the analytic attitude in practice, it should be possible to judge its relevance to, and its ability to achieve therapeutic results in, a particular group of Black South Africans.

The principle research question under investigation in this study is: *How does the therapist and each participant under study respond to the conceptual and practical framework of psychoanalytic psychotherapy comprising the analytic attitude and its counterparts the analytic task, process and setting.* In order to answer this question it was necessary to provide a theoretical context. Chapter two outlines a definition of psychoanalytic psychotherapy and describes the model of the analytic attitude, deriving from Gavin Ivey (1999) that is used in this study. It discusses the evolution of psychoanalysis, and shows how theory and practice have been changed in accordance with shifting epistemologies. This chapter emphasises the adaptability of psychoanalytic theory and makes the point that psychoanalysis as a body of knowledge has a history of assimilating and reflecting societal change and should therefore be capable of adapting to societies that are becoming increasingly multicultural such as in South Africa.

Chapter three situates this study within the field of cross-cultural psychotherapy. The discussion in this chapter is organised around the central concept of the self and maintains that an individual's sense of self is configured in accordance with the needs and demands of his culture. Furthermore it shows how different psychological treatment modalities reflect different configurations of self. The concept of the emerging self, which is applicable to the vast majority of Black South Africans, is introduced in this chapter. It is this emerging self that forms the basis to this study which is ultimately testing whether current models of treatment that are western-centric and dualistic in essence are in fact appropriate tools for treating individuals who are configured in terms of this emerging self.

Chapter four sets out the research methodology and explores the various qualitative options that are available to the researcher for answering the research question. This chapter proceeds to outline in detail the exact procedures that were chosen. A collective case study design represented the most suitable research strategy for the material under investigation. The data collection focus was on the therapeutic dyad which included both the participant and the therapist as the unit of analysis. Three female participants who had committed to long-term psychoanalytic psychotherapy were selected for this case study research. The first 40 sessions of this process for each participant were examined in terms of the central tenets of the analytic attitude. The therapist took detailed notes of each session focusing particularly on the way in which each participant responded to the analytic stance. This note taking related not only to the participant, but also to the stance of the therapist and the maintenance (or otherwise) of the analytic attitude.

In chapter five the data was organised under the five sub-units of the analytic attitude and the analytic task, process and setting. This part of the data collection therefore comprised an

individual case report for each participant. Each session of therapy was detailed under the element of the analytic attitude that was considered to be most prominent for that particular session, such as abstinence. If two or more elements were considered important in one session then this information was apportioned to the respective heading. All eight elements were documented for each participant. The data analysis therefore took the form of three individual case reports, which were condensed into a cross-case report in chapter six. This report was used to test already-established theoretical assumptions and provided a basis for the discussion in chapter seven.

The main focus of this study is on the response to individual psychoanalytic psychotherapy of three Black English-speaking women in transition, and the main benefit of this study lies in making a contribution towards the establishment of this therapeutic model as a relevant and applicable form of treatment to this emerging group. All individuals, regardless of race or culture, suffer distressing symptoms that are unconsciously driven. By utilising the resources and the body of knowledge that derives from mainstream psychoanalysis and by adapting the principles and practice of this model to different cultural groups, it is hoped that a form of treatment can be made available to a group that was previously denied access to relevant psychoanalytic treatment.

CHAPTER TWO: THEORETICAL ORIENTATION

Psychoanalytic Psychotherapy

2.1: Definition of Psychoanalytic Psychotherapy

Psychoanalytic psychotherapy is a form of therapy that is based on understandings drawn from classical psychoanalysis (Bauer, 1990). Psychoanalytic psychotherapy adheres to the fundamental principles of classical psychoanalysis. Essentially, this treatment procedure aims to elucidate into consciousness those neurotic motivations that are unconscious and often cause immense difficulty in daily living (Sandler et al., 1992). Similarly psychoanalytic psychotherapy adheres to certain principles of traditional psychoanalytic practice that must be closely followed in order to allow for unconscious processes to manifest themselves. These principles of practice are enacted within a specific therapeutic frame of working and are embodied in the concept of the **analytic attitude** (Ivey, 1999).

When Freud considered the issue of what should and should not be referred to as psychoanalysis he made the point that resistance and transference were pivotal requirements of the work. He stated “Any line of investigation, no matter what its direction, which recognises these two facts and takes them as the starting point of its work may call itself psychoanalysis, though it arrives at results other than my own” (Freud, 1914). Using this definition Hollender (1965) states that what he refers to as psychoanalytic psychotherapy would qualify therefore as a form of psychoanalysis. The question of how psychoanalytic psychotherapy differs from psychoanalysis was raised as early as 1947 when a committee on the evaluation of psychoanalytic psychotherapy was set up within the American Psychoanalytic Association. In its report in 1952 the committee failed to reach a consensus of agreement on the difference between psychoanalysis and psychoanalytic psychotherapy and was forced to conclude, “that a strong resistance to any investigation of this problem existed among the members of the American Psychoanalytic Association” (Hollender, 1965, p. 6). Whilst a consensus on the differences and similarities of these two ways of working has not been conclusively established, Kernberg (1999) offers a comprehensive and plausible framework of distinction.

In his examination of the relationship between psychoanalysis and psychoanalytic psychotherapy Kernberg (1984, 1989, 1999) points out that this relationship raises concerns of a conceptual, clinical, educational and political nature. He acknowledges that psychoanalysis today consists of a profusion of divergent systems that lay claim to different theoretical understandings and clinical

procedures. However, he maintains the boundary between the two disciplines can be drawn in accordance with the techniques that arise out of the different objectives of each approach. He states that the translation of each discipline's objectives into a technical approach is what characterises and differentiates these modalities of treatment.

In attempting to establish the parameters of psychoanalysis Kernberg refers to Gill's (1954) definition of psychoanalysis as follows: "The facilitation of the development of a regressive transference neurosis, and its resolution by interpretation alone, carried out by a psychoanalyst from a position of technical neutrality" (1999, p.4). Using this definition, Kernberg states "Although Gill himself questioned that definition in later years, I strongly believe… that this is the simplest and, both clinically and theoretically, most useful definition of psychoanalytic method… . I would define interpretation, transference analysis and technical neutrality as three essential features of the psychoanalytic method" (ibid). Kernberg believes that this definition in terms of technique should satisfy the conceptual requirements of the psychoanalytic mainstream. However, he recognises that whilst this definition may be accepted by most Anglophone and French psychoanalysts, as well as the broad spectrum of object relations theoreticians, it may not sit well with the American Intersubjectivist, Interpersonal and Self-psychology approaches. Robert Wallerstein (2005) supports the view that in the face of diversity and theoretical pluralism in psychoanalysis today there is a growing trend towards a convergence or inherent common ground that will define the psychoanalytic discipline. He recognises that on a theoretical level there exist many divergent explanatory systems; however, on a clinical level there exist empirically tested and discernable concepts that are shared by these different theoretical perspectives. Wallerstein proposes that there is a growing impetus in psychoanalysis towards an overarching theoretical and clinical structure that will eventually transcend the theoretical pluralism that currently exists in the discipline. Other authors such as Glen Gabbard (1995) and Robert White (2001) also point to the "common ground" that Wallerstein suggests may ultimately develop into a coherent unified structure of theory, practice and technique in psychoanalysis (Wallerstein, 2005).

Kernberg (1999) states "Psychoanalytic psychotherapy… does not dilute the 'gold' of psychoanalysis with the 'copper' of support, but maintains an essentially psychoanalytic technique geared to analyse unconscious conflicts activated in the transference within a modified framework…". He argues that whilst psychoanalytic psychotherapy uses the same basic techniques as psychoanalysis there are certain quantitative modifications that give rise to qualitative shifts in the nature of the treatment. Whilst the techniques of both approaches are essentially identical the goals of psychoanalytic psychotherapy differ from psychoanalysis in that

the former is often used with patients who suffer severe pathology. For this reason technical neutrality may have to be abandoned in favour of setting limits for life-threatening or treatment-threatening acting out. In contrast technical neutrality in psychoanalysis is ideally maintained throughout the treatment. Whilst transference analysis remains central to psychoanalytic psychotherapy patients with primitive defence structures are likely to exercise splitting operations which may give rise to severe dissociation and acting out, in or out of the therapy context. In such instances it is necessary to modify the transference analysis by establishing linkages between transference developments in the therapy process and events in the patient's external reality. Whilst psychoanalysis relies strongly on interpretation of unconscious meanings, psychoanalytic psychotherapy relies more on clarification, confrontation and interpretation. Interpretation is confined to the 'here' and 'now', rather than to the 'there' and 'then'. These modifications to technical neutrality, interpretation and transference analysis usually arise as the therapy process unfolds. As Kernberg (1999) states, "Any given session of psychoanalytic psychotherapy may be indistinguishable from a psychoanalytic session, but over time the differences emerge quite clearly" (p.1080). It is not the use of the couch or the number of sessions that is conceptually significant when defining the difference between psychoanalysis and psychoanalytic psychotherapy, rather, it is the respective goals of these treatment modalities and the techniques that are adjusted to meet these goals.

Kernberg (1999) acknowledges that recent developments within the Self-psychology, Intersubjectivity and Interpersonal schools, specifically shifts in transference analysis, countertransference utilisation and flexibility regarding technical neutrality may blur the distinctions that he proposes above. However, he maintains that his model of psychoanalysis fits the mainstream, which includes ego-psychology, Kleinian analysis, French psychoanalysis and the British Independents. Kernberg recognises that contemporary psychoanalysis is characterised by a pluralism, unknown in any previous era, which makes it difficult to definitively circumscribe psychoanalysis per se, let alone the differences between psychoanalysis and psychoanalytic psychotherapy. In spite of this Kernberg believes that whilst these approaches are similar the differences between psychoanalysis and psychoanalytic psychotherapy emerge clearly over time and are distinct enough to justify a boundary, albeit common, between these two modalities.

2.2: The Psychoanalytic Procedure

Sandler et al. (1992) briefly outline the basic elements of the psychoanalytic procedure as follows: The therapist establishes a treatment alliance with the patient and the patient is encouraged to talk as freely as possible about the thoughts that come to mind (free association). The therapist maintains a sense of anonymity, with the patient being in possession of relatively

few facts about the therapist (abstinence). The therapist's interventions involve interpretations, confrontations and reconstructions. In the course of free association the patient will inevitably avoid certain material and evade certain topics (resistance). It is expected that material produced by the patient will contain overt or covert references to the way the patient feels about the therapist (transference). Through appreciation of his own emotional responses to the patient the therapist is able to obtain further insight into the patient (countertransference). It is expected that the patient will gain some understanding of the links between his conscious and unconscious tendencies and with the present and the past (insight). A period of time is required for the patient to explore, extend and relive emotionally those insights gained through interpretation (working through). Regressive trends appear as the transference develops; these are generally evident as the re-emergence of childhood wishes and fantasies, feelings and modes of relating that are expressed in behaviour towards the analyst (Sandler et al., 1992, p. 17).

In order for this psychoanalytic procedure to unfold specific requirements need to be met. Psychoanalytic work is a structured endeavour that occurs within certain parameters referred to as the "analytic event". Freud outlined the central requirements and recommendations in his paper on psychoanalytic technique (Freud, 1912). The role of the analyst is to create the conditions for analysis of unconscious processes occurring in the patient and to convey this understanding to the patient. These unconscious processes manifest in the transference phenomena. The essence of analytic work is contained in the transference. Sandler et al. (1992) state that the analysis of transference phenomena is regarded by psychoanalysts as being at the very centre of their therapeutic technique. In order to allow for the emergence of feelings, fantasies and defences towards the therapist in the present that represent displacements of reactions originating from childhood, the therapist is required to adopt a certain disposition and technique.

With changing theoretical perspectives on the analytic situation and process Freud's initial recommendations have been revised. However, it is generally accepted by all therapeutic approaches that hold a strong appreciation of the unconscious that there is a way of working analytically which provides optimal conditions for these unconscious communications to emerge (Ivey, 1999). Those therapeutic approaches that resist the need for anything but minimal structure in the therapeutic encounter generally do not give authority to the workings of the unconscious. However, all depth psychology approaches are keenly aware of the intensely delicate nature of the unconscious and its ubiquitous manifestation in interpersonal relationships. Hanna Segal (1986) states that the role of the psychoanalyst is confined to interpreting the patient's material, and all criticism, advice, encouragement, reassurance, and the like, should be rigorously avoided. The interpretations are centred on the transference situation, impartially taking up manifestations

of the positive and negative transference as they appear. This interpretive activity occurs within the context of what has been called the "psychoanalytic setting" or "frame". Langs (1982) has written extensively on the importance of maintaining this therapeutic frame. He provides good clinical evidence to show that the frame provides conditions best suited to the patient's therapeutic needs. A secure frame creates an atmosphere of trust and security, which is necessary for effective symbolic communication to take place.

Langs (1982) refers to the frame as the ground rules of psychotherapy and states that any rupture to this frame will be experienced negatively by the patient. Even though the patient may express conscious gratification to changes in rules, unconsciously he will comment negatively on such changes. Langs (1982) outlines two important dimensions to the therapeutic frame. Firstly, rules relating to the relationship between the patient and the therapist and secondly, rules concerning the nature of the therapist's interventions. He provides a succinct description of the ground rules of therapeutic work as follows:

1) The spatial, temporal and financial constraints of the setting:

- A single, private, relatively neutral space, free from outside intrusions
- Fixed session duration and appointment times
- A single fixed fee which the patient is expected to pay personally without mediation by any third party.

2) Rules concerning the relationship between the patient and the therapist:

- The absence of any prior, concomitant or post-treatment external relationship between the patient and the therapist and the essential absence of any physical contact
- A one to one relationship with total privacy and confidentiality
- The therapist's maintenance of relative anonymity.

3) Rules concerning the nature of the therapist's interventions:

- Adoption of the fundamental rule of free association
- The therapist's maintenance of free-floating attention
- The therapist's use of appropriate silence, framework management, neutral interpretation, and playback of selected themes having latent significance (Langs, 1982).

Quinodoz (1992) introduces four more important components to the frame as follows:

1) Spatial aspects refer to the conditions of the room including stability and privacy.
2) Temporal aspects refer to the length and frequency of the sessions.
3) Financial aspects include parameters regarding payment for sessions.

4) Refraining from "doing" includes no extra-analytic contact, no retaliation in the analysis and no contact with third parties.

Ivey (1999) pulls together the central threads of the concept of working analytically in his article *Thoughts on the "analytic attitude"*. He draws a distinction between technique and attitude stating that whereas technique refers to a circumscribed set of intentional *behaviours*, attitude refers to a s*tate of mind*. He points out that historically the analytic attitude has not been well defined; this is because attitude has generally been discussed under the rubric of the analytic technique. Schafer's book *The Analytic Attitude* (1983) appears to be one of the very few publications overtly discussing the topic (ibid), but it is implicitly recognised by most depth psychology practitioners that the analytic attitude is the basis of all psychoanalytic treatment. This stance is thus the unifying principle across the different disciplines. "Freudians, Jungians, Kleinians and other theoretical divides may disagree on [the level of theoretical and technical issues] but all would … claim allegiance to the analytic attitude" (Ivey, 1999, p. 2). The analytic attitude refers to a "deeply-rooted, coherent professional mindset that incorporates philosophical, ideological, psychological and ethical concerns". It defines the psychoanalytic practitioner in terms of what he knows, what he believes and how he should conduct himself in the therapeutic setting (Ivey, 1999, p.3). Technique, which most theories have discussed as superordinate to attitude, is seen by Ivey as following on from attitude rather than defining it. Technique is subordinate to and can be defined as the methodological expression and actualisation of this attitude (Ivey, 1999).

2.3: The Analytic Event

Analytic attitude and analytic technique do not exist in isolation but are intimately associated with the analytic task, the analytic setting and the analytic process. These together constitute the *analytic event*. Although in theory the elements of the analytic event can be considered separately, in practice they are indivisible. The analytic attitude exists as a conscious mental disposition on the part of the practitioner that provides a neutral potential space for the emergence of the therapeutic material. The analytic task refers to the rationale for therapy, that of providing the patient with greater insight and psychological freedom. The analytic process refers to the unfolding of the analytic task over time. The analytic setting refers to a literal and metaphorical place which contains the analytic process and is necessary for the unfolding of the analytic task. The technique used refers to interpretations and other interventions which may differ in accordance with different theoretical divisions (Ivey, 1999). The analytic attitude and its corollaries have been poorly defined and inadequately formalised under "technique". While Freud himself in his 1912 paper "Recommendations to Physicians practising Psychoanalysis"

was overtly addressing issues of "technique", he was in fact commenting on "attitude" although he did not describe it as such. Similarly, when Jung introduced his "general method of analysis" he was implicitly referring to some of the fundamental tenets of the analytic attitude. Jung's well-known method included, above all, respect for what is encountered; respect for what is unknown, respect for what is unexpected, for what is unheard of. (Young-Eisendrath & Dawson, 1997). His attitude of generative uncertainty was strongly evident through the mental disposition he adopted when working with the dreams of his patient's. Before attempting to understand a dream he reminded himself, "I have no idea what this dream is all about" (p. 37). In doing so he consciously attempted to free his mind of presuppositions and assumptions that could have undermined the intrinsic meaning of the material (ibid). The following excerpt from Jung's writing shows clearly how he understood the relationship between doctor and patient.

> The uniqueness of the individual and of his situation stares the doctor in the face and demands an answer. His duty as a physician forces him to cope with a situation swarming with uncertainty factors. At first he will apply principles based on general experience, but he will soon realise that principles of this kind do not adequately express the facts and fail to meet the nature of the case. The deeper his understanding penetrates, the more the general principles lose their meaning… [and] the situation becomes increasingly subjectivised (in technical terms transference and countertransference). [The doctor's] profession compels him to have as few preconceptions as possible. Similarly while respecting metaphysical (i.e. non-verifiable) convictions and assertions, he will take care not to credit them with universal validity. This caution is called for because individual traits of personality ought not to be twisted out of shape by arbitrary interventions from the outside. The doctor must leave this to environmental influences, to the person's own inner development, and - in the widest sense - to fate with its wise or unwise decrees. … The responsible doctor will refrain from adding unnecessarily to the collective factors to which his patient has already succumbed. Moreover, he knows very well that the preaching of even the worthiest precepts only provokes the patient into open hostility or a secret resistance and thus needlessly endangers the aim of treatment. The psychic situation of the individual is so menaced nowadays by advertisement, propaganda and other more or less well-meant advice and suggestions that for once in his life the patient must be offered a relationship that does not repeat the nauseating "you should," "you must" and similar confessions of impotence. … As the dialectical discussion proceeds, a point is reached where an evaluation of… individual impulses becomes necessary. By that time the patient should have acquired enough certainty of judgement to enable him to act on his own insight and decision and not from the mere wish to copy convention – even if he happens to agree with collective opinion. Unless he stands firmly on his own feet, the so-called objective values profit him nothing, since they only serve as a substitute for character and so help to suppress his individuality (Jung, 1958, pp. 36-39).

2.4: The Analytic Attitude

As stated above psychoanalytic psychotherapy adheres to certain principles of traditional psychoanalytic practice that are enacted within a specific therapeutic frame of working. Both Freud and Jung recognised that in order for analysis to proceed the analyst was required to adopt a particular stance towards the patient. This stance was later formulated into and described as the "analytic attitude". The descriptive terms used throughout this study to discuss the analytic attitude are those outlined by Ivey (1999) in his article *Thoughts on the "analytic attitude"*. Ivey codified the concept of the analytic attitude into five principles: *Generative uncertainty, Abstinence, Neutrality, Countertransference receptivity and Resoluteness.*

Generative Uncertainty.

The principle of generative uncertainty refers to an attitude of enquiry that Freud outlined as "evenly suspended attention" (1912, p. 111) and what Bion (1970) was conveying in his advice to therapists to approach each session without memory, desire or understanding in order to be open and receptive to what is new and different. It involves a disciplined but unfocussed listening, free from any presuppositions or pre-judgements of the meaning or importance of any part of the patient's communications.

Ivey (1999) introduces the term *generative uncertainty* as an attitude of productive enquiry which stands in opposition to the attitude of unproductive neurotic certainty often held by the patient. Neurotic certainty refers to a particular belief system about the nature of reality that lies behind every symptom. For instance the dependant patient knows with certainty that he is unable to cope on his own. Certainty, whether on the part of the therapist or the patient, implies that meaning has been foreclosed and that one is not receptive to other interpretive possibilities. The therapist who claims to know the patient's problem from the outset is closing off the possibility of further understanding. Freud stated that if the analyst "follows his expectations he is in danger of never finding anything but what he already knows; and if he follows his inclinations he will certainly falsify what he may perceive" (1912, p. 112). Generative uncertainty therefore refers to the therapist's capacity to sit with the tension, ambiguity and ambivalence of "not knowing" and to allow simultaneously for an openness of understanding as to how the patient experiences himself and how he experiences the therapist.

Bion's notion of "without memory and desire" is often misinterpreted. The rationale behind this statement is that by remembering previous sessions new shifts in the transference are not noted and the patient is often given a fixed and outdated identity. Desire refers to the therapist's inclination to selectively listen for information that confirms beliefs and theories which have

already been established. According to Bion (1970) the only issue of importance in each session is the "unknown". He proposes that the therapist should work as far as possible towards a state of mind whereby each successive session should be experienced as if the patient is being met for the first time. As therapists, it is not possible to rely on our own experience, our previous experience of the patient, or on psychoanalytic theory to tell us the meaning of any particular communication. All too often therapists adopt specific roles concerning their perceived function in relation to the patient. Once again this serves to foreclose the possibility that the patient may require the therapist to adopt different functions in accordance with their shifting transference needs (Ivey, 1999).

Abstinence.

The concept of abstinence is frequently criticised from a post-postivistic position as being sterile and anti-therapeutic. Freud's statement promoting "emotional coldness" as a technique of abstinence has set the tone for much debate (1912, p. 118). Furthermore the "Mirror" and "Surgeon" analogies for abstinence proposed by Freud have contributed to this discussion. He stated "The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him"; further "I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skilfully as possible" (1912, p. 115). Whilst Freud's more scientific views of abstinence are less acceptable to modern psychoanalytic psychotherapy the concept of abstinence remains central to the analytic attitude. Freud's suggestion to use a technique of emotional coldness was unfortunate: not only did it fail to reflect his own work but it also has no place within the concept of analytic abstinence generally. On the contrary, analytic abstinence refers more to abstaining from action rather than feeling, nor does it promote the stereotype of a "cold detached therapist". Abstinence creates a reflective space in which emotional receptivity may give rise to empathic understanding. In Ivey's words (1999) "Abstinence… implies feeling spontaneously but acting reflectively" (p. 10).

The principle of abstinence places emphasis on the therapist's disciplined avoidance of those behaviours that may (inappropriately) compromise the evolving transference. Bauer (1993) states that transference requires a gap between what the patient wants and what the therapist provides. This gap is frustrating and creates a necessary sense of ego dystonia. If it is closed by the therapist's conscious or unconscious attempts to gratify the patient's wishes then no analysable transference is possible. The therapist is required to abstain from interventions that obstruct the flow of free association and from frame-breaks that may distort the analytic process. The

therapist's responding differently to what the patient is asking for is an issue which has been raised in a number of theoretical approaches. Bion's "maternal reverie" and Winnicott's "holding environment" both support the notion of a maternal attitude, whilst Lacan emphasises the concept of father and a paternal attitude. Kohut and the school of psychoanalytic self-psychology places strong emphasis on an attitude of "sustained empathic enquiry" (Stolorow et al., 1987, p. 10). In response to the therapist's adopting a particular role Patrick Casement (1985) has the following to say: "If a therapist insists on being experienced as different from the original objects there can be no analysable transference … At best there can only be charismatic cure, which evokes change by seduction" (p. 88). Ivey (1999) further emphasises the need for a therapist to abstain from taking on roles and using analytic metaphors as this obstructs the analytic process by presenting an image which could be contrary to what the patient may unconsciously need of the therapist.

Neutrality.

In recent years increasing attention has been given to the interpersonal aspects of the therapeutic relationship. The concept of the therapist's analytic neutrality has been highlighted and is often taken to mean a restriction of emotionality on the part of the therapist. Unlike abstinence, which refers to a withholding of active behaviours which may affect the unfolding transference, neutrality is the withholding of emotional judgement, bias or partiality on the part of the therapist in response to the patient's experience.

Modell (1989) points out that defence and resistance are not only intrapsychic phenomena but also occur extrapsychically between patient and therapist. An attitude of neutrality on the part of the therapist may therefore evoke defences and resistances that are more to do with the therapist than to intrapsychic unconscious factors. Far from attempting to evoke obstructive responses in the patient the principle of neutrality refers rather to an internal self-reflective and self-questioning process on the part of the therapist. It is characterised by a state of "emotional poise or balance", a "self-reflective suspension" of the therapist's moral and ideological beliefs about the experiences, fantasies and behaviours of the patient (Ivey, 1999). Schafer (1983) points out that one of the rules of analysing is that one should not take sides in the analysand's conflicts. This point is further elaborated by Anna Freud (1936) who states that neutrality is about maintaining a position equidistant from the patient's id, ego and superego. That is, the therapist remains neutral by siding with neither the patient's desires, defences nor critical judgements. Ivey (1999) describes the therapist's neutrality as serving three purposes. The first is to assist patients towards an understanding of their transferential needs by creating "optimal frustration". Secondly, neutrality safeguards the therapist from neurotically identifying with his patients'

needs. Lastly, neutrality protects the patients in allowing them to maintain autonomy and thus a sense of security within the treatment framework.

Countertransference Receptivity.

The interpersonal process of countertransference has been revised considerably since Freud originally referred to this concept as the therapist's unresolved transference to the patient. In spite of this statement Freud himself implicitly recognised the importance of countertransference as a therapeutic tool (Ivey, 1999). The appreciation of how a therapist's emotional response may facilitate rather than hinder the therapeutic process has assumed increasing attention in recent years. With the rise of intersubjectivity, the concept of countertransference has evolved to the point where it is now considered as important as the patient's transference.

Bollas captures the essence of countertransference receptivity in his statement that "in order to find the patient we must look for him within ourselves" (1987, p. 202). Countertransference receptivity therefore refers to the therapist's willingness to allow the patient to manipulate him through transference usage into object identity (ibid). It requires that a part of the therapist - sometimes referred to as the "observing ego" - witness and contain a frequently turbulent and unformed emotional response to the patient (Ivey, 1999). A high degree of responsiveness towards subtle emotional changes in the patients as well as towards their unconscious fantasies is what facilitates countertransference receptivity. In Sandler's words "Parallel to the free-floating attention of the analyst…is what I should like to call his free-floating responsiveness" (1976, p. 45). It is only by the therapist's allowing himself a degree of spontaneous feeling and action, which Sandler refers to as "role responsiveness", that the patient is able to communicate his unconscious experience and make therapeutic use of the therapist. By being open and responsive to the transference manipulations of the patient the therapist allows himself to introject and enact the regressive internal world of the patient. This frequently gives rise to anger or other strong emotional reactions on the part of the therapist, which represent identifications with the patient's childhood family dramas (Ivey, 1999). In such cases the therapist may not be aware of the significance of his behaviour until neutrality has been lost: the importance of recovering an analytic equilibrium and reflecting on the meaning of such enactments is thus crucial to the process (ibid). Personal countertransference feelings that impede the receptivity of the therapist are inevitable and may complicate the process. An awareness of the possible contribution of countertransference to the patient's unconscious experience of the therapist can be safeguarded to some extent through the therapist's own awareness of his internal complexes (ibid).

Resoluteness.

Gavin Ivey states succinctly that "the analytic attitude describes a mode of self-relating as well as a style of relating to one's patients" (1999, p. 15). The maintenance of the tension of the analytic attitude requires resoluteness. Therapists are repeatedly drawn into the unconscious world of the patient and pressured to re-enact primal dramas. Such enactments give rise to strong resistances in both the patient and the therapist which can only be counter-balanced by an attitude of resoluteness. The principle of resoluteness refers to both "courage in the face of the communicative unknown and faith that the process will take its course if we can restrain ourselves from trying to direct it" (Ivey, 1999, p. 15). Resoluteness can thus be described as the therapist's willingness to concede control and tolerate the tension this may create. Ivey states that failure to maintain resoluteness may give rise to deviations in the analytic attitude, usually occurring as a result of countertransference anxiety; this is the anxiety that certain feelings may arise in both the patient or the therapist if the therapist simply listens and refrains from filling the space with questions, advice, or reassurances. It is important to note that in the highly charged atmosphere of the therapeutic event it is inevitable that the therapist will at times lose equilibrium. In this regard, as Ivey (1999) points out, Winnicott claimed that patients sometimes require the therapist to fail them as this often replicates the failures of their own childhood and thereby assists them in getting in touch with such failures (1963).

2.5: The Analytic Technique

Ivey (1999) defines "technique" as the goal-oriented application of theoretical knowledge and states that it is not to be confused with "attitude" which refers to a mental disposition or psychological orientation to the world. Analytic technique is a behaviour predominantly enacted in the form of verbal interventions. Greenson (1967) outlined the verbal components of analytic intervention. He considered the term "analysing" to be a shorthand expression for certain insight-furthering techniques including confrontation, clarification, interpretation and working through. Other authors include certain instructions, questions and constructions as part of analytic technique.

Since the very beginning of psychoanalysis interpretation has been an essential element in effecting therapeutic change and has been considered the most characteristic and most significant feature of an analyst's technique. However, the precise way in which interpretations are formulated varies according to the frame of reference of the therapist. As with other principles in psychoanalysis the concept of interpretation has been modified with changing theoretical developments. The most striking of these changes is the way interpretation is used by the self-psychologists. Psychoanalytic self-psychology deliberately moves away from single

interpretation statements towards reconstructive interpretations. Similarly it moves away from an inferential model towards a more empathic mode of relating. Self-psychology interpretations arise out of a theoretical orientation that places an emphasis on the importance of deficits in early experience. Interpretations that arise out of a "conflict" model as opposed to a "deficit" model are therefore likely to differ in structure and content. An increased interest on transference and countertransference in the therapeutic relationship is reflected in interpretations which now tend to be directed to interpersonal processes rather than focussing predominantly on resistances (Sandler et al., 1992).

Glen Gabbard and Drew Westen (2003) challenge the view of interpretation as the principle method in eliciting therapeutic change. They state that interpretation that aims at reconstruction through "digging for buried relics from the patient's past" (p.824), whilst still useful, is less important than focusing on the here-and-now interaction between the patient and the analyst. They emphasise the point that, "We no longer practice in an era where interpretation is viewed as the exclusive therapeutic arrow in the analyst's quiver" (p.823). These authors propose that there is no single path to therapeutic change but rather change occurs through multiple mechanisms. The idea that there is one basic principle which accounts for all change is strongly challenged as the analyst can no longer lay claim to know everything. In fact 'knowing' is dependent on a collaborative effort of both the analyst and the patient. Whilst these authors do not negate interpretation, they de-emphasise its importance and suggest broadening its use beyond the boundaries of simply interpreting the transference. Mitchell (2002) states that it is not possible to separate insight and relationship as two separate modes of therapeutic action. He points out that over the past two decades this traditional dichotomy has been proved wrong; it is now well understood that interpretations always take place in the context of specific transference-countertransference situations. The analyst is thus seen as a participant observer who constructs the analytic process with the patient. This process includes the personal history and fantasy life of both participants. Interpretations in this context of intersubjectivity speak not only to the patient, but also convey the values, goals and world-view of the analyst (Friedman & Natterson, 1999).

2.5.1: The Analytic Task

The analytic task is the rationale for analytic work. It is the attempt on the part of the therapist to facilitate a degree of psychological freedom in the patient through the insightful resolution of unconscious conflicts (Ivey, 1999). The task of the therapist is to provide a relationship that will facilitate freedom of thought and speech. It does not aim to alleviate symptoms or change behaviour but instead aims at elucidating the unconscious emotional meaning behind the

necessary upkeep of such symptoms. Through the dialogue of "feelings" the possibility is created for these unconscious meanings to be "languaged" into consciousness. As stated by Freud (1937):

> Our object will not be to rub off all the corners of the human psyche so as to produce "normality" according to schedule, nor yet to demand that the person who has been "thoroughly analysed" shall never again feel the stirrings of passions in himself or become involved in any mental conflict. The business of analysis is to secure the best possible psychological conditions for the functioning of the ego; when this has been done analysis has accomplished its task (p.403).

The fundamental task outlined above remains steadfast despite new developments in psychoanalysis from a one-person model to a two-person model. Post positivistic perspectives and intersubjective insights may differ on their understandings of the most effective means to access the unconscious, but would agree that the fundamental task over time remains making conscious those elements that were previously unconscious (Maroda, 2002).

2.5.2: The Analytic Setting

The analytic setting is both a physical and a metaphorical location. It is the place that contains the analytic process and simultaneously provides the "conditions of safety" for this process to unfold (Schafer, 1983). Furthermore the analytic setting provides the necessary boundaries that differentiate and demarcate the world of symbolic communication from the taken-for-granted world of ordinary social intercourse (Ivey, 1999). Whilst the analytic attitude provides an invitation for patients to explore the unfamiliar it is the analytic setting which makes this exploration possible (ibid). The analytic attitude is thus meaningless without the structure of the analytic frame just as the frame is empty without the analytic attitude. However, as Ivey (1999) states, "together…they create the space and atmosphere for the incubation, birth and nurturance of the analytic process" (p. 6).

2.5.3: The Analytic Process

The analytic process is the evolution of the analytic task over time (Ivey, 1999) This process involves the "gradual emergence of ego-dystonic and hence anxiety-provoking unconscious fantasies in the interpersonal context of the therapeutic relationship, and the defensive strategies that patients resort to in order to avoid acknowledging and owning these fantasies" (Ivey, 1999, p. 4). The analytic process therefore refers to a measured increase in conscious awareness that is fostered through the secure maintenance of the analytic attitude.

It is the progressive psychic change in response to the therapist's presence and interventions that comprises the healing aspects of the process (Ivey, 1999). This teleological unfolding of the analytic process in the context of patient and therapist usually occurs along the lines of the patient's internal object world. However, the outcome - which is largely unpredictable - is also strongly influenced by the presence of the therapist, his interventions and the unique inter-subjective quality of the therapeutic relationship (ibid). As stated by Ivey (1999) "it is humbling and comforting to realise and remind ourselves that therapist and patient are part of a process that transcends both of the participants" (p. 5).

2.5.4: Critique of 'The Analytic Attitude' as described by Ivey (1999)

This study relies strongly on the framework of the "analytic attitude" as outlined by Ivey (1999). As shown above, this framework emerges out of the insights and experiences of Freud and Jung and is extended through the work of Segal, Langs and other prominent authors who have contributed towards formalising the psychoanalytic procedure. However, it must be accepted that whilst the framework offered by Ivey (1999) provides a useful and systematic frame for research in this study, it is not representative of all the approaches. Ivey's claim that all psychoanalytically oriented psychotherapies adhere to his interpretation of the analytic attitude should be considered controversial. For instance the American interpersonalist, intersubjectivist and self-psychology schools are strongly critical of the techniques of abstinence, anonymity and neutrality. In fact many critics would state that psychoanalysis today comprises a diversity of approaches that cannot be contained under one rubric. To this end it could be stated that there is no single "attitude" but rather a variety of different "attitudes" that belong to different psychoanalytic approaches. Having said this, Ivey's attitude holds true to the three concepts that Kernberg (1999) feels are central to mainstream psychoanalysis and psychoanalytic psychotherapy, namely technical neutrality, transference analysis and the interpretation of unconscious meanings.

New developments in psychoanalysis have given rise to concomitant developments in the analytic technique. These conceptual developments and their related techniques present a significant challenge to mainstream psychoanalysis and for that matter a challenge to the analytic attitude proposed by Ivey (1999). These new currents are predominantly organised around the intersubjective and interpersonal approaches that include both self-psychology and the cultural psychoanalytic tradition expressed through contemporary interpersonal psychoanalysis. Stolorow, Brandshaft and Atwood (1987) introduced the idea of objectivity and pointed out that the concept of intersubjectivity was a response to the belief in classical psychoanalysis that there is an 'objective reality' known to the therapist. They proposed that the only reality in therapy is a 'subjective reality'. The essence of this shift is captured in the words of Jessica Benjamin (1990)

who states, “An enquiry into the intersubjective dimension of the analytic encounter would aim to change our theory and practice so that where objects were, subjects must be” (p.34).

Self-psychology focuses on self-object transferences as the principal matrix of treatment. In doing so it moves away from technical neutrality, emphasising rather, emotional attunement and immersion in the subjective world of the patient. This approach also promotes an anti-authoritarian stance on the part of the analyst and questions the privileged nature of the analyst’s subjectivity (Kernberg, 1999). This position is upheld by the intersubjective and interpersonal approaches who support the notion that personality develops continuously in a relationship matrix, rather than in the context of drive expression, conflict and defence. The analyst’s role is to compensate for past overstimulation or understimulation of the patient’s archaic self. This requires the therapist to focus intently on the intersubjective nature of the relationship. Emotional growth on the part of the patient is dependent on new affective interpersonal experiences that arise in this intersubjective encounter. Clearly, the intersubjective position attempts to overcome the boundary between subject/object, therapist/patient. It emphasises mutual exchanges, conscious and unconscious that point to a fundamental inter-relational dynamic in the therapeutic encounter. This inter-relational aspect was previously not acknowledged by classical psychoanalytic approaches that focused on intrapsychic determinism.

These conceptual shifts have implications for analytic technique. Most importantly, these shifts question the traditional positivist view of the analyst’s objectivity in interpreting the patient’s transference. Abstinence, neutrality and anonymity have very little place in the intersubjective model that proposes a constructivist imperative. Interpretation in this model relates to exploring developments in the affective exchange between patient and therapist and the extent to which the patient assimilates this new affective experience (Kernberg, 1999).

Merton Gill (1994) emphasised the interactive nature of the analytic process and argued for an expansion of the traditional understanding of the analytic situation in one-person terms to an understanding that includes two-person considerations. He was critical of the rigidities of strict Freudian analytic etiquette that excluded any consideration for the influence of the analyst on the patient. In this model the analyst could be assured that the patient’s feelings towards the analyst (transference) were merely distortions or displacements from significant figures in the patient’s early oedipal life. Gill argued that this classical analytic frame did not remove the analyst’s influence on the process, it merely denied it, attributing everything that happened to the patient’s fantasies and projections. Patients are much more engaged with the ‘here-and-now’ analyst than

analysts are inclined to accept, and therefore the analyst's participation is a key feature of everything that happens in the analytic situation (Mitchell, 1995).

Mitchell (2000) extends Gill's position of contemporary psychoanalysis and presents his understanding of relationality by describing that the basic motivation in human experience is the engagement with other minds, not biological pushes from within. He emphasises that minds interpenetrate one another and are shaped in relation to each other; that the patterned processes in minds reflect the patterned processes between minds; that ways of being with oneself are inseparable from ways of being with others; and that subjectivity develops always in the context of intersubjectivity. This understanding is supported by Zeddies (2001) who states "The analyst does not only see the patient's world, he or she inhabits it" (p.2). Mitchell emphasises that traditional psychoanalytic theory presumes an individualistic, monadic view of human experience that minimizes, if not completely avoids, a full acknowledgement of the extent to which human beings are interconnected and interdependent from the beginning of life. For Mitchell, psychoanalysis is therefore perspectival and constructed, not universal and absolute (Zeddies, 2001). He further suggests that the relationship between the analyst and the patient is at the centre of the analytic solar system, the hub around which everything else in the analytic process orbits, and the reference point against which all interventions and communications are defined (Mitchell, 1997).

For Mitchell the most important challenge to analysis is to find a way out of the paradoxical impasse in which the potential for transformation is translated into the familiar and static. He feels that most psychoanalytic theories do not attend sufficiently to the issue of 'relational influence'. Instead these theories attempt to cross the gap between the analyst's understandings and the patient's problems by advocating clinical concepts such as interpretation, empathy and unconditional positive regard (Zeddies, 2001). Mitchell therefore endorses the idea that psychoanalysis is about exploring and transforming deeply rooted conflictual experiences, but he challenges the idea that non-directiveness is the best route to uncovering these dynamics (ibid).

Safran and Muran (2001) suggest that the interpersonal and relational perspectives allow for greater technical flexibility. By being freed from classical notions of therapist abstinence and neutrality such perspectives are able to focus on a constructive relational experience that is a critical component of change. They emphasise the point that rather than relying on some inflexible and idealised criterion such as therapeutic neutrality the analyst should be guided by what a particular therapeutic task means to a particular patient in a given moment. They also suggest that ruptures in the therapeutic alliance are the royal road to understanding the patient's

core organising principles (ibid). Owen Renik (2004) explores the notion that as most psychoanalysts today would in principle agree that intersubjectivity is a part of the psychoanalytic event, how does this affect theory and practice? He points out that whilst the importance of countertransference has been well recognised in psychoanalysis, the concept itself and the way in which it is generally used reflects a compromised understanding of the intersubjective nature of the analytic event. Furthermore he argues that by acknowledging the intersubjectivity of the therapeutic encounter we are obliged to re-define the nature of the analyst's expertise and authority. If insights are co-created by analyst and patient and are not simply the product of the analyst's objective expertise per se, then it is not possible to give prominence to the analyst's voice as this would prohibit circularity in the clinical investigation. This circularity is further obstructed through the longstanding principles of analytic neutrality and abstinence. He states that if it is accepted that analytic truths are co-created, then the rationale for minimising personal self-disclosure on the part of the analyst becomes obsolete.

Theodore Jacobs (2002) provides a balanced perspective on these techniques under debate in the literature. He recognises that the shift to an interpersonal position has added significantly to psychoanalysis; however, he points out that these gains have been at the expense of abandoning some of the older techniques of accessing the unconscious. He suggests that the most effective pathway to understanding the unconscious is one that utilises techniques which focus on both the intrapsychic (one-person) and the interpersonal (two-person) dimensions of the analytic experience. He states that the interactional style with its focus on the here-and-now, specifically concentrating on interpreting the transference, can obscure the importance of evenly suspended attention and for that matter, the importance of listening. He also points out that an over-enthusiastic understanding of the positive use of countertransference can overshadow its negative impact (Jacobs, 2002).

Jacobs believes that some of the older generation techniques provided a sufficiently quiet and reflective space which was useful in accessing primary process thinking and other primitive aspects of the patient's imaginary world. Whilst he agrees that progress in psychoanalysis should adopt new interactive and communicative ways of understanding the mind, he also believes that an integration of some of the older techniques will amount to the most creative use of the analytic instrument (Jacobs, 2002). This is a view proposed by Bollas (1999) who states that in any given session a patient can oscillate between a one-person mode of relating and a two-person mode. At times the patient will speak to the therapist as an internal object with which he is communing and at other times the patient may address the therapist in such a way that the therapist feels his otherness is being called into interpersonal engagement. Bollas likens this to everyday life where

a person may at times find himself lost in thought in the presence of another person and at other times intently engaged in dialogue with another person.

It can be argued that whilst these theorists are emphasising the point that a relational intersubjective position is more conducive to understanding the patient's problems, they are not suggesting that the analytic process becomes loosely interactional. Some form of distinction between the analyst and the patient must be contained. Hoffman (1994) suggests that the therapist must at times 'throw away the book' in order to demonstrate a genuine willingness to place the patient before the rules of therapy. He believes that spontaneous deviation from the conventions of practice opens up the possibility of a more authentic engagement. On the other hand, throwing away the book has in some circles 'become the book'. Slavin and Kriegman (1998) describe how the new order of spontaneity and self-disclosure has become idealised to the point where it now represents a new codified system of practice that reflects the collective agenda of new factions and schools of thought. They suggest that what is required is not a new set of rules and technical guidelines, but rather a new sensibility that recognises that any attempt to codify the analytic encounter will inevitably become biased towards the needs and views of those who advocate it (ibid). Owen Renik (2003) points out that the challenge for contemporary analysis is not in doing away with psychoanalytic standards of practice but lies rather in formulating a set of standards that takes into account the heterogeneity of the psychoanalytic community. He points out that responsible standardisation represents an effort to get away from a kind of self-glamorising vagueness that excuses psychoanalysts from accountability (Renik, 2003). Ivey's model of the analytic attitude provides one attempt in this direction.

By sufficiently negotiating many of the controversies discussed above, Ivey (1999) offers an interpretation of the analytic attitude that is well informed and provides a usable account of the ground rules for psychoanalytic psychotherapeutic practice. This 'attitude' is not inconsistent with contemporary relational understandings of the analytic encounter. The current intersubjective climate has ostensibly abandoned the notions of 'neutrality'. However, the way in which Ivey presents this concept is more in line with Jacob's (2002) vision of creating a 'reflective space' rather than with the traditional positivistic notion of 'non-interference' and 'restriction of emotionality'. 'Neutrality' in Ivey's model does not imply lacking in care and empathy, rather it refers to a self-reflective suspension of the therapist's moral and ideological beliefs. Similarly, Ivey's concept of 'abstinence' refers to abstaining from action, not from feeling. This attitude creates the necessary conditions for 'emotional receptivity' on the part of the therapist and fosters a climate for what Ogden (1996) refers to as 'reverie'.

Abstinence in Ivey's model goes far beyond the traditional one-person model of a withholding, authoritarian stance. His use of abstinence refers to the therapist being consciously aware of not taking on roles that are contrary to the unconscious expectations of what the patient requires the therapist to be. As pointed out above, one of the criticisms of the intersubjective model is that increased emphasis on interaction in the here-and-now reduces the possibility for 'quiet reflection' that is necessary in order to access primary process thinking. Ivey's particular use of abstinence and neutrality allows for the meditative space that gives rise to the intersubjective 'analytic third' that Ogden (1997) refers to. Ivey's model places a strong emphasis on the transference-countertransference dimension of the analysis. In this sense he raises the importance of the analyst's subjectivity to a level that is consistent with relational two-person models of analysis that emphasise a need for greater mutuality. Ivey's 'attitude' acknowledges the impact of conscious and unconscious communication and in doing so it incorporates an understanding of intra-psychic and interpersonal exploration in the analysis. His concept of 'generative uncertainty' reflects a non-directive openness to interpretive possibilities and is aligned with Bion's (1970) concept of 'not knowing'. Such a stance goes far beyond the traditional notions of the therapist being imbued with all knowledge and certainty. In fact Ivey's suggestion of sitting with the tension and ambiguity of "not knowing" is highly consistent with postmodern logic.

Clearly the model proposed by Ivey (1999) is open to controversy. However, for the purpose of this research study Ivey's description of the analytic attitude was considered to provide a useful blend of new generation (two-person) and older generation (one-person) techniques that have been sufficiently re-worked into a relational paradigm. His emphasis on the subjective, interpersonal, imperatives of contemporary psychoanalysis places the 'analytic attitude' in a framework that is free of the one-person, objective, structural and deterministic imperatives of classical psychoanalysis.

Psychoanalytic Developments

2.6: The Evolution of Psychoanalysis

Psychoanalysis "is often regarded as being a completely integrated and consistent system of thought, but this is far from being the case" (Sandler et al., 1992, p. 1). In fact psychoanalysis has undergone many adjustments through the course of time. Freud himself was responsible for modifying and in some instances completely revising his original concepts. As he successfully developed new insights he subsequently added new dimensions to technical procedures. This process of mutability in psychoanalysis has been a trend that persists to this day. Many of the

concepts are not all well defined, and changes in their meanings have occurred as psychoanalysis has developed and aspects of its theory have changed (ibid). For this reason, when discussing one or another concept in psychoanalysis, it is important to take an historical approach and to locate the meaning of the concept in its historical time and the context in which it was used. The situation is complicated further by the fact that different schools of psychodynamic thought have inherited and then modified certain concepts for their own use: for instance the Freudian terms such as *ego, self* and *libido* have different meanings in Jungian psychology (Sandler et al., 1992).

The widening scope of psychoanalysis, which began in the 1950's, has given rise to a significant extension of meaning to many of the core concepts. In recent years much attention has focussed on expanding the classical metaphor of the analyst-as-a-mirror to the more contemporary understanding of the analyst-as-a-partner in the analytic situation. This has resulted in a more comprehensive understanding of the dimensions of transference and countertransference.

Two important developments have occurred in the evolution of psychoanalytic theory and practice in recent years. Mitchell (1993) and Hoffman (1991) both state that these two paradigm shifts can be broadly described as a shift from drive reduction to the relational paradigm, and from positivism to what Hoffman refers to as a "constructivist or perspectivist epistemological position" (1991, p. 77). He suggests that our experience of reality in this position is constructed by culture and society, and how we experience therapy is influenced by our therapist. Both perspectives reflect a postmodernist stance which moves away from the classical position that emphasises the universality of psychoanalytic concepts. Rubin states:

> It has been known for some time that psychoanalytic theories about human nature are not universal but specific to time and place. Freud's psychoanalysis seemed to work for sexually repressed middle-class Viennese in the late 19th and early 20th century, but has less relevance to the social and psychological problems of contemporary western culture (1997, p. 1).

Postmodern epistemology poses a significant challenge to the traditional views of human nature and the concepts of self and object inherent to classical thought. As a result it has had a strong influence on re-shaping contemporary psychoanalytic theory and practice. A postmodern approach believes firstly that truth is situational and relates to social consensus as much as reality, and secondly that different groups of human beings create widely diverse pictures of human nature, each supporting the indigenous power structure of the group creating it (ibid). The postmodern position deconstructs the objective-subjective dichotomy of the therapeutic relationship: the therapist is no longer a neutral objective observer but rather a participant. It has

been suggested that, "postmodern psychoanalytic theories may have value in overcoming some of the problems of cross-cultural therapy encountered in traditional practice, because these theories affirm the validity of different experiences and perspectives" (Rubin, 1997, p. 6).

2.7: Historical Developments

The historical developments in psychoanalysis are best discussed in terms of phases outlined by Sandler et al., (1992) and Wollheim (1987). The first phase was essentially pre-psychoanalytic and lasted until 1897. This phase involved the mutual work of Freud and Breuer and was characterised by the application of hypnotic methods to hysterical patients. Real traumatic events were thought to lie behind the symptoms of the neurotic patient. Based on this traumatogenic theory of neurosis treatment involved attempts to force the forgotten memories into consciousness, simultaneously bringing about a discharge of affect in the form of "catharsis" or "abreaction" (Altman, 1995).

Freud's rejection of the trauma theory of neurosis heralded the second phase in psychoanalytic development. In this phase attention shifted from external to internal factors and the emphasis was placed on the role of unconscious wishes and the way these impulses manifested themselves on the surface. It was at this phase of development that many of the core concepts of psychoanalysis were laid down (Wollheim, 1987). Freud's *Interpretation of Dreams*, published in 1900 outlined the process whereby unconscious wishes seeking direct expression conflicted with the individual's assessment of reality and with his ideals. This conflict between instinctual forces and repressive or defensive forces gave rise to the construction of a compromise formation (Sandler et al., 1992). The compromise formation represented an attempt to allow fulfilment of unconscious wishes in disguised form. Manifest dream content and free associations were seen as disguised or censored derivatives of unconscious wishes. Thus Freud established three important dimensions to the "mental apparatus": the conscious system, the preconscious system and the unconscious system. This became known as the "topographical model". The unconscious system was seen as containing instinctual drives and wishes that constantly sought expression into the conscious system but simultaneously posed a threat to the conscious ego. If this content were allowed into consciousness it would give rise to unpleasant and disturbing feelings and was therefore defended against. Expression of such wishes was therefore only allowed into consciousness in distorted or disguised form. Preconscious material contained knowledge and thoughts outside of consciousness but more accessible and not as strongly contained by the forces of repression (Altman, 1995).

The third phase was signified by a decisive shift in Freud's conceptualisation of mental functioning. In the *Ego and the Id* (1923b) Freud introduced the "structural model", later referred to as the "second topography". In this paper he put forward a revised formulation of the mental apparatus which accounted for the increasing complexities and inconsistencies that could not be explained through the initial topographical model. The concepts of id, ego and superego were introduced and the central role of the ego as mediator between the demands of the id, the superego and the external world was emphasised. The compromises created by the ego amidst these conflicting demands were seen as the basis for personality (Sandler et al., 1992). Furthermore under certain conditions these compromises gave rise to symptomatology that represented the best possible adaptation of the ego to specific circumstances.

The fourth phase in the development of psychoanalysis included contributions from analysts beyond Freud (Sandler et al., 1992). Anna Freud's *The Ego and the Mechanisms of Defence* (1936) extended the notion of defence and Hartman's 1939 publication of *Ego psychology and the Problem of Adaptation* introduced the popular notion of "ego psychology". In the 1960s "ego psychology" gradually gave way to significant new developments, such as Heinz Kohut's "self psychology" and the "Object relations" perspectives of Edith Jacobson, Hans Loewald and Otto Kernberg. Kernberg's views were drawn from the well-established theories of Melanie Klein and from Ego Psychology. British contributions to psychoanalytic theory were extensive and were drawn mainly from the Kleinian school and object relations theorists such as Ronald Fairbairn, Michael Balint and Donald Winnicott. The theories of Wilfrid Bion provided new extensions to theory, as did the work of Jacques Lacan. Developmental theorists such as Margaret Mahler, Daniel Stern and Robert Emde provided invaluable insights into the psychoanalytic understandings of human development (Sandler et al., 1992).

Psychoanalytic theory has thus undergone considerable elaboration since Freud. There has subsequently been much criticism of Freud's original concepts. Nonetheless, it is important to point out that much of what constitutes current psychoanalytic thinking is based in essence on insights from the second and third phase of development - for instance, clinicians continue to make use of the topographical model and the structural model when describing problems encountered by their patients (Sandler et al., 1992).

2.8: The Movement Towards a Constructivist/Relational Perspective

The drive reduction model outlined by Freud is based essentially on the understanding that human beings are internally pressured to discharge and gratify biological instincts (usually sexual), which are often at odds with culture and environment. Normal development is measured

in terms of the individual's success in negotiating culturally acceptable expressions for these drives. In this model "Objects" or significant others are seen as a means to gratification or release and are linked to instinct (Greenberg & Mitchell, 1983).

The British object relations theorists introduced a major shift in psychoanalytic theory by moving the emphasis from drive reduction to the satisfaction of drives within the context of early care-taking experiences. Human potential was seen as being realized within the context of relationships, with the basic unit of personality being a relational one. Objects were no longer construed in terms of Freud's instinctual drive theory but were seen rather as fantasised images of significant others with which the subject interacts (Ivey, 1990). Melanie Klein felt strongly that human infants sought love and understanding in addition to nourishment and Fairbairn (1952) reinforced this view by stating that libido is object seeking rather than pleasure seeking. Winnicott further emphasised the importance of the family environment in development, by suggesting that, "we cannot describe the baby without describing the environment" (Winnicott, 1965/1969).

This relational model heralded a move from the more mechanistic metaphor of Newtonian logic toward a post-Einsteinian model of relativity in which there is no such thing as a context-free event: every thing occurs in relation to another thing (Alvarez, 1992). The understandings embedded in this relational model introduced a way of working with patients that was previously not amenable to classical psychoanalytic work (Ivey, 1990). It was also able to focus on a level of psychopathology and associated symptomatology, etiology and psychodynamics that classical psychoanalysis was theoretically and practically not equipped to work with. Psychopathology was seen as arising from the internalisation of disturbed interpersonal relations in early childhood and not from instinctual frustration (Ivey, 1990). Relational theory introduced a stronger emphasis on the here-and-now of therapy and on the interpersonal relationship between the therapist and patient. Rather than simply attempting to uncover repressed material the therapist was more acutely aware of the interpersonal relationship. The concepts of projective identification and introjection of split off parts alerted therapists to a level of interaction - even in apparently well functioning patients - that required a different technique. These new developments to theory required a more textured way of working that took into account the changing transference of the patient, the changing countertransference of the therapist in the here-and-now and consequent changes to techniques in intervention.

The second important shift in psychoanalysis is the move from positivism to constructivism. The classical position of the therapist as the arbiter of reality and an objective observer has given way

to an appreciation of the therapist as a participant in the construction of reality. Hoffman (1991) points out that in order to move from a positivistic position to a constructivist position the therapist needs to recognise that his personal participation in the process of therapy has a continuous effect on what he understands both about himself and about the patient, and that this relationship involves a world of mutual influence and constructed meaning. Altman (1995) refers to this development as a shift from the one-person model of psychoanalysis to a two-person model. He claims that such a model is more amenable to cross-cultural work as it locates the mechanism for change in the relationship between the therapist and the patient rather than relying purely on the patient to develop insight. He also states that a relational model can overcome some of the problems that may be encountered when working with individuals from a non-western culture. A more directive approach, which is action oriented rather than verbally oriented may be necessary. For instance the therapist may be required to offer material assistance or advice. Altman (1995) states that central concerns such as the patient's pre-occupation with material deprivation become problematic within a one-person model but are more easily dealt with in a two-person model. He states that adjustments to abstinence and neutrality can be accommodated in the two-person model "without necessarily compromising the analytic stance, mitigating against the development of the transference, or rendering the transference unanalysable" (1995, p. 63).

2.9: Contemporary Developments in Psychoanalysis: Conceptual, Clinical and Technical

H.S Sullivan in the 1930's and W.R.D Fairbairn in the 1940's introduced the beginnings of a broad shift in understanding human experience which has evolved into various psychoanalytic relational perspectives: interpersonal, two-person psychology, intersubjectivity, relational, interactional, mutuality and field or systems theory (Mitchell, 2002). This shift to a two-person model has taken a firm foothold in American Psychoanalysis and is often contrasted with the traditional paradigm of the one-person model reflected in classical, drive theory and ego psychology (Spezzano, 1996).

Mitchell (2000) describes the essential feature of these new perspectives as the understanding that humans are principally defined by their relationships. To understand truly the individual's experience is to understand the interpersonal contexts in which the person lives. The basic unit of study, therefore, is not the individual as a separate entity whose desires clash with external reality, but rather the interactional field within which the individual is situated. From this perspective the unconscious could no longer be viewed in the same light as in the classical model. Mitchell (2001) states that in postclassical analysis the unconscious refers less to specific content to be uncovered than to a kind of experience to be opened up. The classical understanding of the

unconscious and how to access its meanings gave rise to a great body of technical procedures to govern consulting room behaviour for analysis. These parameters included a non-directive approach that did not interfere with the freedom of the patient's free associations. Non-interference was therefore a means to allowing for the patient's unconscious derivatives to emerge. Exposure of these infantile sexual and aggressive conflicts at their points of fixation was followed by interpretation and ultimate transformation (ibid). A position of objectivity, neutrality, abstinence and listening for unconscious derivatives meant that the conscious here-and-now dimension of the analytic dyad was under-emphasised.

Mitchell (2001) suggests instead cultivating an experience in the immediate analytic relationship, which is free of goals and less driven by secondary process concerns (such as effectiveness, productivity and performance), a relationship that is more open to affective currents, fantasy and imagination. He proposes a mode of relating that is in essence meditative and similar to Jung's concept of 'active imagination', Ogden's notion of 'reverie' and Winnicott's idea of 'going on being'. Simultaneously, however, Mitchell rejects the classical notion that analysts should not concern themselves with symptoms because symptom change will automatically occur when underlying conflicts have been resolved. He maintains that a more pragmatic involvement with the patient, searching for alternatives and stretching the patient's imagination through "thought experiments" can be useful in transforming highly obstructive symptoms and behaviours (2001, p. 3).

Contemporary psychoanalysis has broadened itself far beyond the task of simply making the unconscious conscious (in the language of the topographic model) or of transforming id into ego (in the language of the structural model). It is more concerned with fostering the capacity of the analyst and the patient to create a space that lies between reality and fantasy (Ogden, 1996). Ogden refers to this space as "the intersubjective analytic third" which is an unconscious intersubjective construction produced by the individual subjectivities of both the analyst and the patient. In this model the analyst gains access to a greater understanding of the patient's unconscious internal world through using his own unconscious in the service of being receptive to the 'drift' of the patient's unconscious (ibid). Ogden emphasises that the analyst's reverie experience provides an indispensable avenue to understanding the intersubjective analytic third and thus to understanding and interpreting the transference-countertransference (1997). Spezzano (2001) reinforces the notion that access to unconscious activity can be gained through techniques that reach beyond the classical understanding of merely listening for free associations. He proposes three sites of access: free association, the analyst's reverie and the intersubjective drama jointly created by the analyst and the patient.

If the conceptual model of relationality proposed above is to be the new grounding for analytic treatment then it follows that new systems of technical procedure will emerge. In the one-person model of analysis it was understood that by 'free associating' and receiving accurate interpretations transformation would occur. The idea that 'information' leads to transformation has been revised in a two-person approach. Emmanuel Ghent (1995) points out that most relational theorists recognise that what the patient requires is an 'interactive' experience. There is a need in the patient for a 'quality of experience', a need to be deeply recognised in the here-and-now, without which therapeutic effect will be minimal. Natterson (1993) states that a relationship that relies solely on interpretation and objectivity is not therapeutic. He proposes a movement beyond neutrality and suggests creating a mutual experience of intersubjectivity where the affective experiences of both the therapist and the patient are relevant. He points out that such a relationship of warmth and concern is necessary for interpretation to be effective. Interpretation in the absence of this intimacy may prove little more than an intellectual exercise. Ogden (1994) broadens traditional techniques of interpretation by emphasising the concept of interpretive action, which involves communicating aspects of the transference-countertransference to the patient through activity (e.g., facial expression) rather than verbal communication. He also challenges the Freudian concept of 'the fundamental rule' which entails encouraging the patient to say whatever passes through his mind. In an interpersonal matrix Ogden argues that such a 'rule' is antithetical to the analytic experience of creating a capacity for reverie. He states that it is important for the patient to know that he is free to be both silent and free to talk.

Karen Maroda introduces the controversial technique of "deliberate self-disclosure" on the part of the therapist (1999, p.1). This technique has never been considered an acceptable part of traditional analytic practice and is currently treated cautiously by most interpersonal, intersubjective and relational approaches. She claims that self-disclosure is an essential component of any analytic practice that aims to make repressed affect conscious and is necessary in providing affective attunement between the therapist and the patient. Maroda (1997, 1999) is critical of contemporary relational theorists stating that she recognises a general reluctance on their part to alter psychoanalytic technique to accommodate new two-person theories, "preferring the safety of trying to fit one-person pegs into two-person holes" (1997, p.323).

Chodorow (1996) reminds us that structural thinking and determinism in psychoanalysis is on the wane. Contemporary psychoanalysis is no longer bound to clinical understandings and interpretations that flow out of developmentally created objective structures that rely on theories of childhood development and its determinative effects on the psyche throughout life. She states

that psychoanalysis has throughout its history relied on causal explanatory models describing the analytic encounter in terms of libidinal fixation, or ego, or self structures that are being enacted. The contemporary focus on the here-and-now shifts away from universalist claims about the panhuman content of unconscious fantasies, the temporal continuity of the self, the belief that life unfolds in a coherent stages from past to present to future and that transference is construed in terms of past psychic realities enacted in the present. Chodorow claims that "what is expressed in the analytic encounter is fed by infantile sources, but it is also fed by many sources in daily life – by the moment-to-moment animating of and investing the world with subjective meaning, and by the new meanings that emerge in the interchange between two (or more) people" (1996, p.32).

In this poststructural theoretical climate analytic knowledge is required to release itself from developmental, universal understandings of the human mind and focus rather on emergent meaning in the transference-countertransference that is mutually constructed rather than intrapsychically caused by one person. In the words of Steven Stern (2002) "In today's postmodern climate, the concept of self as a coherent and enduring psychological structure is under siege. The self is not unitary but multiple, not static but in flux, not a separate centre of initiative, but intersubjectively constituted" (p. 694). Conceptual shifts of this nature have implications for the development of an analytic technique that must take into account subjectivity rather than objectivity, ambiguity rather than certainty and fluidity rather than fixation.

As is evident above, the plurality of contemporary psychoanalytic perspectives presents a significant challenge to the foundations of mainstream notions on technique. Psychoanalysis in a constructivist postmodern age with its revised theoretical understandings of core concepts such as the self, the unconscious, transference, countertransference, dissociation and projective identification has created further tension in the search for a universal system of standards. Aron (1999) states that traditional psychoanalytic theories do not highlight the individuality of the analyst or the uniqueness of the interactive matrix. Whilst contemporary psychoanalysis puts the interactive matrix at the center of its theoretical and methodological agenda, this should not be at the expense of surrendering ethical standards, professional responsibility, or clinical judgement. On the contrary he maintains that the postmodern sensibility of contemporary relational and intersubjective psychoanalysis requires that the analyst accept full responsibility for the fact that it is his own personality and subjectivity underlying his values and beliefs which upholds and infuses his theoretical convictions. From this perspective there can be no technical choice or clinical decision that is not imbued with the analyst's subjectivity (ibid). Aron points out that analytic technique has always been, and currently remains under, revision. However, the search for a standard technical procedure becomes obsolete when it is accepted that "the individuality of

the analyst as well as the particularity of the analysand makes every analysis a unique and unrepeatable event" (1999, p.12). In the words of Stern (2002):

> Postmodern psychoanalytic theorists view themselves as abandoning the linear, hierarchical and essentialist models of the mind, represented by Freud's structural theory and Kohut's self psychology, in favour of a decentered, open, and 'horizontal' model wherein subjective experience is understood to be in a constant state of flux between discontinuous self-states that are grounded in the history of a person's relational experience (p.694).

In summary it can be seen that psychoanalysis has moved from the classical model of one-person psychology with its intrapsychic, structural and deterministic model of the mind towards a two-person model that takes on intersubjective postmodern sensibilities. In spite of these developments, intersubjectivity is in itself not a unitary system. The term intersubjectivity often has different meanings for different approaches. While most approaches support the concept of mutual reciprocal influence defined by Stolorow and Atwood (1994), two-person theorists such as Mitchell (1997) have been criticised for not sufficiently recognising the ongoing influence of the analyst. Karen Maroda (1999) in turn criticises Stolorow and Atwood stating that whilst they recognise mutual influence they fail to verbalise this mutual influence to the patient, rather they use such insights to inform their interpretations alone. Jessica Benjamin (1992) introduces a shift to standard intersubjective theory by showing that therapists' and patients' attempts to influence one another can be both positive and negative with periodic impulses from both sides to destroy connection and meaning.

Many critics feel, however, that the intersubjective two-person pendulum has swung too far. They state that there is too much emphasis on the here-and-now and the analyst's experience. As a result the regard for the unconscious has notably declined (Grotstein, 1999). Jeanne Wolf Bernstein (1999) points out that whilst the new relational perspectives have released us from the antiquated Freudian notion of the neutral analyst it now "allows for psychoanalysts to be preoccupied by and enamored with their own musings by listening more to their internal echoes at the expense of their patient's intrapsychic conflicts" (p. 281).

New understandings of basic concepts of the mind have radically influenced technique and clinical practice. These developments continue to shape an ever- evolving discipline. However, it is important to note that several voices are beginning to emerge that are critical of the subjective nature of the analytic relationship. They claim that this position relies heavily on a philosophical perspective rather than on a pragmatic one. Maroda (2002) states that "once we admitted to our countertransference and the mutuality of the analytic encounter, we did not have a clear idea of how it should be handled in the consulting room" (p.102). Maroda is suggesting that technical

shifts have not kept up with philosophical shifts, and that more emphasis needs to be placed on how these new intersubjective understandings can be translated into technical procedure.

2.10: Adaptability of Psychoanalysis to Non-Western Cultural Groups

Throughout most of the twentieth century into which psychoanalysis was born there has been significant social upheaval, war and changes in economic conditions that have caused mass migration. Analysts and patients have changed countries of residence, culture and language. As a result psychoanalysis has been obliged to change its predominant language and adopt new customs and standards of "another world" (Kadyrov, 2002). It can be said that since its birth psychoanalysis has been developing in the context of a rapidly changing multicultural and multilingual world. With increased international mobility of different cultural groups psychoanalysis is being constantly challenged to pay attention to cultural and linguistic differences on the level of theory, practice and procedures for training (ibid).

With these tensions in mind the issue of psychoanalysis across cultural and linguistic divide formed part of the 42nd Congress of the International Psychoanalytical Association, Nice, France, 26th July 2001. Psychoanalytic propositions continue to be modified, added to and amended in the light of new developments and changing analytic experience. This study claims that psychoanalysis is constantly adapting to the social needs of the societies that it serves. Whilst the drive theory of Freud's nineteenth century Vienna seemed well equipped to deal with the repressions of the time it has proved largely inadequate to deal with other levels of pathology that appear in a modern and postmodern society. Relational theory arose in response to a need for treatment of patients that could not be conceptualised in the classical model. The revolution of intersubjectivity and postmodern approaches of relativism and constructivism reflect the complexity of industrialised society today. However, whilst psychoanalysis has adapted swiftly to the changing needs of western cultural groups it has moved at a slower pace with regard to adapting to non-western cultural groups further a field. In spite of this, cross-cultural therapy is becoming more a part of everyday practice in western countries and psychoanalysis is beginning to reflect this change. With the introduction of psychoanalysis into Russia, Eastern Europe, the Middle East, the Far East, South America and South Africa amongst others it is fast becoming a cross-cultural discipline of international practice and discourse.

2.11: Summary

When discussing the difference between psychoanalysis and psychoanalytic psychotherapy it must be recognised that although the objectives of each approach are different, both approaches use similar techniques. However, these techniques are adjusted to suit the differing treatment

goals of each approach. As contemporary psychoanalysis becomes increasingly characterised by a pluralism of divergent systems it becomes more difficult to distinguish between modalities. Ivey (1999) attempts to codify the analytic process by proposing the “analytic attitude”. Whilst his position is open to criticism, he offers a model of practice that is highly self-reflective on the part of the therapist, a model that re-works many of the older order understandings of abstinence, neutrality and anonymity. This model is consistent with the two-person model of intersubjectivity that characterises recent developments in psychoanalytic thought. The intersubjective position has emerged in response to the classical belief that there is an ‘objective’ reality known to the therapist. They propose that the only reality in the therapeutic encounter is a ‘subjective’ reality. This movement in thought has given rise to similar changes to technique. Interpretation is no longer emphasised to the extent that it was in the modernistic framework. Relationality presents a strong challenge to the concepts of abstinence and neutrality and it places more emphasis on the interpersonal dimensions of the encounter. This movement from the intrapsychic one-person model to the interpersonal two-person model provides a more flexible framework that is able to incorporate the challenges that increasingly present themselves today in terms of cultural and linguistic difference. The more postmodern intersubjective model inherent in the analytic attitude proposed by Ivey (1999) is more amenable to cross-cultural work than the classical one-person model of the modernist era.