# IMAGINING POSSIBILITIES: A QUALITATIVE STUDY OF ANALYSTS' FAITH IN THE PSYCHOANALYTIC PROCESS

by

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Abstract

IMAGINING POSSIBILITIES: A QUALITATIVE STUDY OF ANALYSTS' FAITH IN THE PSYCHOANALYTIC PROCESS

by

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This qualitative study is an exploration of psychoanalysts' faith in the analytic process. The fundamental belief is based on the principle that reflection on and awareness in one's mental processes is a valuable and transformative experience. Faith in psychoanalysis is conceptualized as a dynamic process in which analysts' doubts and despair in clinical situations are met with experiences that restore their ability to imagine possibility and positive change. These doubts, which are triggered in various ways, lead the analyst to enlist a series of "non-analytic" actions and thoughts that can precipitate a breakdown of the analytic framework and/or inconsistent application of other analytic tools. The dissolution of certain analytic tools can culminate in a crisis of faith in the analytic process. Analysts' faith can be restored through means that shore up the

individual's sense of self. Once this happens, analysts return to an analytic stance, thus re-establishing a tempered, positive belief in the process.

For this study ten psychoanalysts were administered semi-structured interviews and asked to discuss their experiences of faith in psychoanalysis; how they think about it, how they enact it, how they lose it and how they restore it. The data is presented in a manner that provides the reader with a nuanced view of faith. General patterns that developed amongst subjects are presented in tandem with subjects' individual experiences of faith. By looking at the data from these two perspectives, the reader has an opportunity to see the full, detailed and idiosyncratic nature of this topic.

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# Table of Contents

# Introduction

In a Dark Time

In a dark time, the eye begins to see
I meet my shadow in the deepening shade;
I hear my echo in the echoing wood—
A lord of nature weeping to a tree,
I live between the heron and the wren,
Beasts of the hill and serpents of the den.

What's madness but nobility of soul
At odds with circumstance? The day's on fire!
I know the purity of pure despair,
My shadow pinned against the sweating wall,
That place among the rocks—is it a cave,
Or winding path? The edge is what I have.

A steady storm of correspondences!
A night flowing with birds, a ragged moon,
And in broad day the midnight come again!
A man goes far to find out what he is—
Death of the self in a long, tearless night,
All natural shapes blazing unnatural light.

Dark, dark my light and darker my desire.
My soul, like some heat-maddened summer fly,
Keeps buzzing at the sill. Which I is I?
A fallen man, I climb out of my fear.
The mind enters itself, and God the mind,
And one is One, free in the tearing wind.

Theodore Roethke (1964)

Theodore Roethke speaks eloquently to the matter of faith and its relationship to despair and crisis. In the field of psychoanalysis, where faith and doubt often move together, "A man goes far to find out what he is— Death of

the self in a long, tearless night." And this "man" is everyman; he is the patient and he is the psychoanalyst.

The nature of analytic work subjects the analyst to the same pressures as her patients; she must confront her fantasies, wishes and destructive impulses (Jacobs, 1999, p. 315). In acknowledging these forces, the analyst comes face to face with her own beliefs and doubts. The patient and the analyst share the common condition of humanity which involves plotting a course between their doubts and hopes, the "dark light" and even "darker desire" of which Roethke speaks. In particular, it is the analyst's subjective experience of hope and doubt and how it bears on faith in the psychoanalytic process that will be the focus of this research.

The problem of faith in the analytic process is personally relevant, in that I have wrestled with the notion both as a patient and a practitioner. As a patient, I have often felt doubt, fear, and despair. It seemed to me that crumbling to bits was the only next step. It was my therapist who seemed to think otherwise. She seemed aware of things unseen, which comforted me. Whether from an idealizing transference or sheer desperation, I believed that my therapist "knew" something that I did not. Her capacity to imagine something growing out of the emotional

chaos I was experiencing created a type of cohesion for my treatment and for me. This capacity, this trust in the therapeutic process was essential. As a training therapist, I am again confronted with questions of faith, belief and doubt. Now I am in the position to offer the tacit but potent message that things will be all right. Over and over again, I am forced to consider what "all right" means.

In part, this study is an attempt to grapple with this question. Faith in my work and in myself is vital to conceptualize , as it is a belief that is communicated to my patients. My personal beliefs in the analytic process have largely emerged through an ongoing struggle to integrate a realistic assessment of both my strengths and my personal limitations. I have found that the more I am able to accommodate Roethke's "dark light" and "darker desire," the more capable I feel and the more I have faith in the analytic process.

When I think about my role as a training psychotherapist, I am in awe of the process, of the surprises and the unexpected moments when I feel confident and hopeful, and the times when I feel cynical and depleted. I have come to realize that my early experiences of clinical work usually left me feeling rattled and unsure. As my idealization of this work has been pared down

to a more realistic view, there is less emotional fluctuation. I expect that the painful process of seeing psychoanalysis (and seeing myself) for what it is and what it can do has been most useful. I have come to accept that this is not a process that will necessarily 'cure' someone and make him 'normal'. Rather, it is a paradoxically expansive and limited process that allows the individual to recognize his own mind and his own stories. It is through this recognition, that the possibility of change or the ability of acceptance can occur.

Psychoanalysis is complicated and ambiguous work. In one sense, my faith in the analytic process is a matter of holding on to hope for growth, change and ever-developing humanity for both my patient and myself. One psychoanalyst I interviewed for this thesis described his experience in ways that evoked some of my own feelings:

> There is something uplifting about this work…. It feels human and healthy to relate to another person in a [non-controlling] way and not use them. You can facilitate another person's development so they can go on to be more evolved, to be humane to other people.

The word "uplifting" captures an important experience of therapeutic work. At those moments when the analyst's faith in the process, the patient and herself is realized, a connection occurs so that both the therapist and patient

feel strengthened. Those are the moments when the analytic process expands and becomes active and alive.

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An initial definition of faith is in order. Despite its common associations with religion, the word "faith" has a fairly broad meaning. In the Oxford English Dictionary faith is defined as: (1) an unquestioning belief; (2) a loyalty or allegiance to a person or thing; (3) a belief that does not rest on logical proof or material evidence (1999, p. 1514). Webster's New Twentieth Century Dictionary adds to the popular definition of "faith" as a quality of complete trust or confident belief in the truth, value, or trustworthiness of a person, idea, or thing-- "as children have *faith* in their parents." (1986, p. 658).

As I conceptualize it, analysts' faith in the psychoanalytic process is based on the principle that reflection on and awareness in one's mental processes is a valuable and transformative experience. This positive belief is balanced with realistic limitations and built on the intersection of hope and doubt. I see faith in psychoanalysis as a dynamic process in which analysts' doubts in a clinical situation are met with significant experiences that restore the ability to imagine possibility and change, even in the face of despair.

These doubts, which can be triggered in various ways, lead the clinician to enlist a series of "non-analytic" actions and thoughts that can precipitate a breakdown of the analytic framework or to inconsistent application of other analytic tools. The dissolution of analytic tools culminates in a crisis of faith in the analytic process. Analysts' faith in the psychoanalytic process is then restored through means that shore up the individual's sense of self. Once this happens, the analyst can return to an analytic stance and re-establishing faith in the analytic process.

In my view, faith is not the same as hope. Rather, faith is a process that develops and evolves through a constant interplay of hope and doubt. At best, hope is embedded in faith and is essential to it. (Faith, on the other hand, is not necessarily part of hope.) While hope provides a partial foundation, it also runs the risk of overtaking faith or masquerading as it. If hopes are borne out of unrealistic fantasies and remain unsubstantiated, then they can weaken one's faith. Then again, if there is an absence of hope and one is overwhelmed by difficulty, disappointment and limitation, faith has no room to flourish.

In a sense, faith is kept honest by the balance doubt gives hope and vice-versa. Doubt that is balanced can be beneficial and supply the impetus for a psychoanalyst to explore further and seek firmer ground. Despair, which is a magnification of doubt, is destructive and can quickly corrode one's beliefs altogether. Hope and doubt and their relationship to faith thus have important implications for psychoanalytic work.

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The analyst is constantly required to place her trust in the unknown which raises a number of questions. Where does the analyst turn for assurance? How can she be certain that the analytic method is the appropriate approach? Nina Coltart writes:

> However much we gain confidence, refine our technique, decide more creatively when and how and what to interpret, each hour with each patient is also in its way an act of faith; faith in ourselves, in the process and faith in the secret, unknown, unthinkable things in our patients which, in the space which is the analysis, are slouching towards the time when their hour comes round at last. When that hour comes, by dint of all our long, thoughtful, interpretive attempts to familiarize ourselves with our patient's inner world, we begin to see shaping up things that we may have guessed at, predicted, or theoretically constructed or relied on… or things that take us by surprise. (1995, p.3)

Coltart emphasizes the importance of the analyst's trust in her work while highlighting the significance of doubt. In

considering the valuable characteristics of doubt, one can begin to see how the unknown pieces leave room for new information to emerge and for surprise to enter the field. And in this space that is created , there is opportunity for the analyst's and patient's unconscious to play.

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Faith in the psychoanalytic process is not a common topic in the psychoanalytic literature. I would like to suggest that this study and its discussion of faith in the analytic process begin to fill a neglected area in current analytic thinking.

The concept of hope appears to be written about more readily than faith. Since I consider hope to be a building block of faith, a review of the concept is worthwhile. The term hope has been defined and redefined to fit a number of experiences. For instance, hope has been conceptualized as something that is immature: Searles (1977) characterizes a type of hope as "unconscious-denial-based, unrealistic." Similarly, hope has been classified as "malignant" (Ghent, 1992), "non-productive (Buechler, 1995) and "deleterious" (Ahktar, 1996). Though the labels vary, they all interpret hope as an undifferentiated, idealized wish that can foster immature and damaging longings.

At the other end of the spectrum, hope has been defined as a healthy, productive and positive force. In 1962, Menninger writes about the importance of hope and claims that it is "an indispensable factor in psychiatric treatment and education" (French and Wheeler, 1963). There are current theorists, such as Wallerstein (1986), Mitchell (1993), and Cooper (2000) who indicate that hope can be conceptualized as a balanced, realistic and mature belief in the future. I aim to build a discussion of faith that will include some of these conceptualizations about hope.

In post-Freudian theorizing Loewald discusses the potential of the patient as observed by the analyst (1956). Here we see that "potential" can be interpreted an expression of the faith of the patient and the analyst, as it represents the idea of promise, of some form of imaginable future development. Contemporary writers, like Mitchell (1993) and Cooper (2000, 2003) do not speak directly of faith but, by using the terms of hope and dread, examine related ideas that they deem as crucial elements to growth: acceptance of limitations of self and other, as well as an acknowledgment and working through of such experiences as despair and destruction. These concepts are similar to Roethke's idea that one can be

"free in the tearing wind." Bion (1963), Coltart (1995) and Safran (1999) look at faith in the psychoanalytic experience in yet another way: they introduce and grapple with a Buddhist-influenced approach to "not knowing" as a type of belief. These views consider kind of faith that requires one to live in and through "the dark light." Ahktar (2006) presents his ideas on how faith in taken up by the clinician, first borrowed from senior colleagues and then eventually integrated into one's belief system.

All of these theorists have contributed to my view of faith in various ways. For instance, Loewald's theory of potential leads me to think about the balance of holding open possibility while acknowledging life's limitations. Mitchell and Cooper's ideas on hope and doubt speak to the growth that comes from "dead ends" while Safran, Bion and Coltart's ideas teach me ways to respect what we cannot know within the psychoanalytic arena. By synthesizing these conceptions, I will explore how faith acts as system of meaning that assists in organizing one's life.

***

A number of publications and conferences have explored conceptualizations of hope and faith and the roles they play for the patient (APA Div. 39 Conference (2003); Cooper (2000); Shabad (2001); Ahktar (1996). But the problem of

the *analyst's* faith in the psychoanalytic process has historically been neglected.

It is my contention that an examination of the analyst's faith in psychoanalysis has been split off because it may appear too exciting and threatening a topic. With a discussion of faith comes the acknowledgment of doubt and even despair. Conveying the experience of faith and doubt is very personal, and such profound soul-searching can leave one vulnerable. For the analyst, to talk about "pure despair" and the transcendence of it is to talk about who she is in the room with a patient, and who she is in her life in its totality.

A discussion about faith may also become complicated for the analyst if she maintains the fantasy that she should "know it all." An honest exploration that addresses her doubts and sense of efficacy can entail difficult admissions. Despite this, and perhaps also because of it, I feel that an open discussion about faith and doubt is important to develop because the insecurities and harsh self—judgments that can shake every analyst keep clinicians isolated and disconnected from one another.

In a culture that values results and outcomes, a process that is rife with ambiguity and doubt is difficult to sustain. There are misunderstandings that doubt makes

one weak, not potentially stronger. This makes this study all the more important, because it is an attempt to capture the grounded yet ephemeral qualities of analytic work. As the analytic process cannot be quantified and contained, neither can the faith. In this way, this research goes beyond the finite, and parallels the analytic process.

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The question of faith is also important in a larger context. In a sense, the analyst's faith in the analytic process may be about believing that she has provided the analysand with the tools required to live life fully and meaningfully. Mitchell's point that the analyst's knowledge and expertise is informed by his relationship to the patient and limited by being human brings in the existential question of faith (1993).

In every treatment, there are moments of doubt and confidence for the analyst; an eager patient certainly will become stymied at certain points. Likewise, a patient who seems intransigent may in fact become an active analysand. Neville Symington (1983) writes about a difficult case that occurred early in his career that has greatly influenced the type of analyst he has become. Through this case, Symington understood the significance of his inner

emotional state: “I came to realize that the “place” where psychoanalysis occurs is in the inner life of the patient and also the analyst” (p.302). Keeping this in mind, one can see how the interaction between the analyst’s hopes and doubts influence her work.

It is the experience *within* the analyst that I see as greatly shaping her confidence and faith in the analytic process. According to Lifschitz, being able to tolerate fragmentation, chaos, confusion and ambiguity is, for the analyst as for the patient, an important achievement (2001, p. 78). Bion (1963) asserts that analysts need to develop this capability in order to truly help patients tolerate similar experiences. As the analyst is alerted to her own process, her work with patients will be necessarily affected. She also becomes aware of the issues that may arise if the patient’s faith is qualitatively different from her own.

The analyst’s faith in the analytic process as a whole, as well as her faith in an individual treatment, may influence what can be accomplished in an analytic situation. The analyst’s subjective experience is inevitably part of the process and therefore productive to understand. By the analyst becoming aware of her personal

feelings in relation to each patient, analytic endeavors are likely to prove more successful. Searles stresses the importance of the analyst being open and willing to experience the gratifications and deprivations of analytic work, no matter how taboo they are in the conception of the neutral analyst. This "openness" refers to the recognition of the analyst's own feelings and hopes, which are full of love, ambivalence and destruction. He argues that it is directly connected to the treatment's capacity (Searles, 1978).

In the process of writing and thinking about this topic of faith, it has occurred to me to explore even more fully the subjectivity of the analyst. By teasing out and refining even further the analyst's experience of self, I hope to understand and assess the ways faith in the analytic process and faith in the patient affects the work. I plan to explore the relationship between analyst's faith in process, patient and self. The themes that have arisen in my thinking have led me to review the following literature.

## *Literature Review*

While historically the issue of faith may not have been an explicit theme within psychoanalytic theory, the possibility of change and the importance of curiosity are assumptions on which the analytic process rests, and these are essential qualities of faith.

The goal of this study is to explore psychoanalysts' faith in the analytic process. This research will be an examination of analysts' professional and personal experiences and the ways that analysts' beliefs and doubts in the analytic process affect their work. The literature review will provide a context for the issues that are present in the field of psychoanalysis. The progression of literature domains is designed to systematically establish a background for understanding conceptions of faith.

The ideas of potentiality, hope and faith have been understood in various ways. In this review of psychoanalytic literature, I will organize and clarify some of these conceptions. I will also review theories about how these notions affect the analyst and color an analytic treatment.

**Overview of Literature Domains**

I have divided the literature relevant to the topic the analyst's beliefs in and about psychoanalysis into four domains. They are:

I. Theoretical Background On Hope and Faith
II. Contemporary Theoretical Perspectives On Hope and Faith
III. Analytic Tools as an Expression of Faith
IV. Analysts and Their Work

The first domain includes theory that develops the ideas of the recognizing the patient's potential within psychoanalysis, and the role of the analyst as a component in therapeutic change. Literature in the second domain explores recent theories that build on earlier ideas and lend themselves to more exact and explicit theorizing about both hope and faith.

The third literature domain focuses on the importance and use of analytic tools. Specifically, there will be a summary of ideas that involve the significance of the frame, use of concepts like enactments and interpretation, transference and countertransference. In the fourth and final domain I will look at the relationship between the analyst and her work and review some of the literature that discusses the interaction between the analyst's personal self and professional self. By looking at these two areas

—faith and the analyst's experience— I hope to open up commonalities and differences in analysts' thinking about faith and its impact on their work.

## *I. Theoretical Background on Hope and Faith*

### *Hans Loewald*

The work of Hans Loewald provides a foundation for analytic conceptions of hope and faith. In Loewald's 1957 paper, "On the Therapeutic Action of Psychoanalysis," he asserts the importance of potentiality and explores the connection between ego formation, object relations and the activity of the analyst. As the analyst works to ally herself with patient's ego functions, the patient becomes interested in the investigative process and in herself. Loewald points out that the patient is reliant upon the interaction, and the therapeutic relationship helps to establish "an organizing, synthesizing ego activity" (p.229). The analyst works to reach his patient, in part, through the privileged access he has to the core of the patient (p. 229). The analyst must work to bring out the patient's true nature, rather than impose his own concept of what the patient should become. Loewald notes that to do this requires the objectivity and neutrality that mark "the essence of which is love and respect for the

individual and for individual development" (p.229). Loewald does not detail the privilege of the analyst, but I will suggest that the analyst's faith in the analytic process and in the therapeutic relationship is essential to this. In part, my research is an attempt to examine this issue: is it the analyst's belief in her work (or in her patient) that places her in such a position, or does she have access to certain facts that allow her to bring out the patient's "true nature"?

When Loewald draws the parallel between the therapeutic relationship and the parent-child relationship, he explains that the parent is engaged in an empathic relationship in which he holds "a view of the child's future and mediat[es] this vision of the child in his dealing with him" (p.228). In this, Loewald implies the analyst-patient relationship, like the parent-child relationship, is fueled by faith. He goes on to say that it is the parent's own experience and knowledge of growth and the future that informs this. The more the parent sees and knows about herself, the more she can mediate to the child. Consequently, through identification, the child can grow. As Loewald notes, "the child begins to experience himself as a centered unit by being centered upon" (p.230).

In a similar way, the analyst's personal experiences feed her belief in the process. In one of the pilot interviews for this study, an analyst noted:

> My own therapy is a giant roadmap for my work with patients. … I've always known that Dr. L holds a wholer version of me in his head. And he knows, his "knowingness" helps me believe that I'm going to move through something and that I can offer something to others…

The analyst's experiences become essential features in allowing her to hold a vision of the patient. The analyst, like the parent, must be able maintain the delicate balance of following the patient and being ahead of his development as well. Though Loewald introduces the way the analyst thinks about and envisions the growth of the patient, this theory rests on the view that the analyst is in a superior position. Loewald does not examine the analyst's subjective experience or the analyst's view of the analytic process. I believe that the analyst's ability to anticipate potential growth is an expression of faith: it is the glance towards the future.

Loewald writes about the potentiality that underscores each analytic interpretation. Each elucidating comment by the analyst works towards developing a foundation for understanding. She puts into words what she believes the patient can take up, thus ushering the patient to a higher level of organization. Loewald sees interpretation as

consisting of two parts: the first is a step towards true regression, which leads to the second, in which the patient recognizes the higher integrative level to be reached (p.240). As the analyst uses her own unconscious as a tool, she must be able to regress within herself to the same level of organization as the patient. What Loewald does not address here is the idea that the analyst has to be able to let herself go, to trust in something outside of herself, which will allow her the psychological freedom to dive the depths of the patient's unconscious. Just as the artist must disconnect from concrete experience in order to enter a productive and creative space, so must the adult analyst.

Since the analyst cannot know exactly the patient's terms and what could happen and what could be, clearly faith plays into the process. Loewald (1962, 1973) observes that emancipation is the result at the end of a successful analysis. If the feelings of mutual abandonment can be analyzed and the therapeutic relationship, rather than the object, is internalized, then the work is productive (Tessman, 2003, p. 211). In a sense, the relationship and more importantly, the experiences evoked by it are managed within it and taken in by the dyad, then

there is the possibility of them informing future experiences.

***Sandra Buechler***

Sandra Buechler (1995) presents a more exact view of hope, one that is not merely a phenomenon for the patient but for the analyst as well. She builds on Loewald's theory of therapeutic action, and begins to cross over from the patient's realm into the analyst's domain by engaging the interplay between the patient's hopes and the analyst's hopes. In "Hope as Inspiration in Psychoanalysis," Buechler maintains that the clinician is called on to understand what is good for the patient. This is a reminder that clinicians are active participants in the process and hold a vision of the potential of which human beings are capable[1].

Buechler considers the evolution of hope within a treatment and suggests that it is a phenomenon that is modeled by the therapist for the patient. Much in the same way that anxiety is passed from mother to infant according to Sullivan (1964), hope is transmitted from analyst to patient.

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[1] The implications of thoughts framed as good or bad vis-a-vis the patient raise the question of a value system which may be imposed on a treatment. With regard to faith and hope, it also brings to light a parallel to the value system imposed by religion.

Buechler characterizes hope as expectation and inspiration. In defining hope and considering the triggers of it, Buechler suggests that the analyst's whole relationship to life is what engenders hope in the patient. Buechler describes it this way-- in order for the analyst and the patient to bear the "how" of analysis, the "why" must be understood. As the patient observes the analyst's struggle to make sense out of things, and perceives the analyst's "why", he sees the analyst willing to work hard, stumble and recover. The patients sees that his analyst wants to live, even within the most difficult emotions. The analyst does not cower in the face of her patient's or her own terrifying experiences (1995, p.170). Through example, the analyst communicates that she interested not in being correct, but rather in personal growth. Buechler continues:

> I think that what mainly creates hope is the patient's experience of finding a way to relate to such a person. For many, this task requires substantive changes, alterations in all components of the emotion system. The deepened curiosity and joy, the lightened envy and hate that results engenders hope. (page 72)

And for the analyst, being able to relate in this way and to be related to in this way engenders an ongoing faith in herself and human interaction.

In reading and thinking about hope, I have found that it often becomes so overloaded with expectation that it is no longer beneficial. It leads the analyst to focus on an unattained future, leaving the present issues unattended. Buechler joins other theorists in her acknowledgement that hope's regressive and nonproductive qualities can interfere with one's present experience. She contends that hope can be understood as a defense against resignation — a waiting for, as opposed to an appreciation of the present. Bromberg (1999), writing about Loewald, points out the dilemma the analyst faces:

> The paradox of the analyst as holder of the patient's potential has been eloquently developed by Friedman (1988, pp. 27-34) who states (following Loewald, 1960) "That one sort of childhood need which is not only sought in analysis, but is also fulfilled by analysis, is the need to identify with one's own growth potential as seen in the eyes of a parent. Being reacted to like that not only provides hope in general but structures reality in a relevant and promising fashion"(p.27). But, says Friedman, "Hope can only be a present hope, in the shape given it by the patient's present psychological configuration. In other words, the analyst must accept the patient on his own terms, and at the same time not settle for them. If he does not accept the patient on his own terms, it is as though he is asking him to be someone else, the patient will not have cause for hope, and he will not recognize the analyst's vision. If the analyst settles for the patient's terms, he is betraying the patient's wish for greater fulfillment."(p. 34)

## *II. Contemporary Theoretical Perspectives on Hope and Faith*

### *Tensions of Hope: Stephen Mitchell and Steven Cooper*

***Stephen Mitchell***

In Hope and Dread in Psychoanalysis (1993), Stephen Mitchell outlines the shifts that have occurred within the field of psychoanalysis and transformed theory and practice profoundly. Mitchell discusses the new wave of thinking that focused on self experience, rather than the classical idea of searching for the hidden truths based on early childhood experiences and impulses. As Mitchell outlines the themes and trends of different psychoanalytic schools of thought, he finds that meaning-making has become a major component of analytic work. Hope and dread are evoked, because the issue of belief is an integral part of organizing and implementing change.

In tracing the evolution of psychoanalysis, Mitchell examines two major questions: *what does the patient want?* and *what does the analyst know?* Mitchell suggests "there has been a marked shift from the clarification and renunciation of infantile fantasies to the revitalization and elaboration of the patient's sense of personal meaning" (p. 27). Mitchell contends that as the culture has shifted, so has the objective of psychoanalysis. Freud's method and goal was to increase the patient's capacity for "love and work." Now, as psychoanalysis has become a

source of orientation and meaning for the individual, expression, creativity and authenticity have become central to the analytic mix.

The focus of the second question -- what the analyst knows -- has shifted from "a representation and reflection of the underlying structure of the patient's mind to a construction, an interpretation of the patient's experience" (p.67). The changing role and participation of the analyst has therapeutic reverberations, most critically a growing emphasis on the impact of the analyst's experience. Here Mitchell attempts to get at the question of the analyst's privilege to which Loewald referred. What *does* the analyst know that gives her the skill and advantage to help the patient gain insight? Rigorous training provides a substantial base, but the analyst's "life experience" is increasingly understood to constitute essential (and variable) knowledge as well. Thus, the analyst's subjective experience of faith and doubt may be communicated to the patient and provide him with an opportunity to observe or change aspects of himself which are in need of care.

The collaborative relationship between the analyst and the patient is a cornerstone of relational theory, which asserts that the hopes and beliefs of *both* participants

inform the analytic situation. Both the patient and the analyst want the patient to develop greater insight or be different. It is the confluence of the patient's and analyst's hopes that determines the course of and outcome for the work (p.209).

Mitchell views the analytic situation as a negotiation between analyst and analysand. Rejecting the neutrality of classical analysts, Mitchell suggests that psychoanalysis "is operating within the complex tension generated by the deeply personal encounter between the analyst and the analysand and the hopes and dreads of each" (p.9). These hopes are seen as beneficial and understood as strength, rather than "something to be unmasked as an infantile wish that must be renounced" (p. 45). Mitchell moves beyond Loewald's ideas here as he explores the mutual impact of the interaction between patient and analyst.

Regardless of theoretical orientation, there is general agreement that analysis involves two individuals and that this clearly influences the analytic process. Mitchell writes, "The analyst's experience of the patient's desire is codetermined by the interaction of the range of potentials that compose the patient's repertoire, on the one hand, and the range of constructive identifications that are available to the analyst at any given time"

(p.178). The contemporary analyst is interested in looking at both the ways in which she affects the process and the ways she is affected by it. While the patient's inner world is of utmost importance, the analyst's inner world is also recognized. For instance, the patient's doubts about or criticisms of the analytic process can evoke a genuine crisis for the analyst, compelling the analyst to face the limitations of her insight, understanding, and ability to help the patient. As Mitchell acknowledges:

> The analyst's understanding, no matter how transformative and comforting it may be, is incapable of warding off … losses, conflicts and limitations. Their meaning may change in some way over the course of an analysis, but the actuality of human pain, conflict and suffering imposes constraints on the range of possible meanings. The realization is painful—for both patient and analyst. (p. 213)

For the analyst, to be confronted by her limitations and "helplessness in the face of some of the deepest sources of human suffering is cause for dread indeed" (p. 214). Mitchell suggests that when the analyst is confronted by this dread, when she is humbled and silenced, some of the most productive work can occur. Through the analyst's reflections and acknowledgment of struggle, a new kind of hope can be rekindled. It is this rebirth of hope that I propose is actually the engagement of faith. The

crises of dread and doubt compel the analyst to consciously address her beliefs in herself and in the analytic process, and imagine what is possible and what is not, and generates a wiser, more complex kind of belief.

The analyst's capacity to imagine what is possible, particularly as a way to emerge from a fog of futility and hopelessness in which she may be lost, is more than hope--it is faith. In fact, in the psychoanalytic process, as the unconscious becomes even more unyielding and wilder, faith may be the anchor that orients the treatment, particularly if the analyst and patient are swept up in the whirlwind of projections and enactments.

***Steven Cooper***

A recent book to grapple with the issue of hope is Steven Cooper's Object of Hope: Exploring Possibility and Limits in Psychoanalysis (2000). Cooper understands hope to be a motivating force in psychoanalysis and a central purpose in the profession. The belief of possibility is not only in the process, but also in the therapeutic relationship. Building on Mitchell's ideas, Cooper suggests that hope is textured by many elements including envy, disappointment, and frustration Cooper continues:

> Objects of hope are by definition, potentially or even inevitably, in a powerful position to exert change. This power derives both from what patients

> endow us with and from the hope that analysts have towards their patients. Furthermore, because of the potential for aroused wish and need, objects of hope are also often objects of disappointment, destruction, danger, competition and envy. Our patients, like our children, become the repository of our hopes… .(p.xii)

Although Cooper explores these tensions, he does not address what supports and frames hope. I suggest that while the analyst may hold idealistic views of psychoanalysis, faith is what scaffolds the analyst and her beliefs in the midst of conflict and crisis. Cooper raises the question of how to integrate the analyst's hopes with respect for the patient's conflicts and hopes. This powerful dilemma calls for a deeper examination of what analysts hope for and how these hopes are expressed consciously and unconsciously.

Cooper's discussion of hope acknowledges the destructive elements of one's internal world. He believes that by allowing for loss of idealizations and simultaneously working to accept disillusionment, the individual promotes the birth of healthy hope. [2] Cooper organizes his ideas in terms of the tensions created

[2]Similarly, Searles writes that "A healthy capacity for hope is founded, quite in contrast to manic denial of depression, on past experiences of the successful integrating of disappointments--past experiences, that is, of successful grieving" (year). Klein's theory also explored this in her conceptualization of the paranoid-schizoid position and its preservative powers, and the more mature integrated capacity one has in the depressive position (year).

through different facets of therapeutic action: intimacy and solitude, conscious and unconscious experience, disclosure and privacy. In struggling to reconcile the losses and limitations found in psychoanalysis, kernels of hope can sprout and take root. Likewise, by addressing the frustration and loss inherent to some of the paradoxes of the analytic process, change can develop.

Cooper, like Mitchell, sees hope and dread on a temporal spectrum[3]. Hope is tied to anticipation--a question of what will come. Dread, its counterpart, is related to fears of what has already occurred.[4] He points out that the most hopeful parts of human growth involve loss and mourning. By including the relationship between hope and dread in treatment, the analyst shifts from an examination of patient's past to include an analysis of how the patient represents the future.

For the analyst, the span of past to future also has significance. Her observations and feelings may be informed by past experiences, but each interpretation and expression is a push towards something in the future. As Cooper

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[3] [3] Solomon underscores a similar temporal relationship in his discussion of depression. He suggests that depression is a response to past loss, and anxiety is a response to future loss. He quotes Thomas Aquinas: "Fear is to sadness as hope is to pleasure"(year, p. 65). This would be an intriguing area to explore further.

states, “Reconstructing the future relates to how the analyst’s wish to influence their patients, even as they consciously try to interpret the past and present” (p.xiii). Much as Loewald explores the analyst’s regression as a tool for change, Cooper grapples with the paradox of therapeutic action.

Cooper examines Loewald’s ideas on interpretation and examines them through the lens of hope. By discussing the tension between disclosure and privacy, he acknowledges that the ways in which analysts construct psychic possibility implicitly or explicitly varies. Interpretation is related to the analyst pushing the patient forward: “Most psychoanalysts experience a constant tension between acclimating to the patient’s psychic reality and trying to heighten to the patient’s capacity for observation and integration of less immediately available aspects of affect and conflict” (p.197). For example, if the analyst sees an experience differently from the patient within the analytic setting and discloses that, something is revealed. There is an attempt by the analyst to define her subjectivity and in doing so, she becomes a new object for the patient. According to Cooper, the patient’s reaction to the analyst’s subjective experience can open an exploration into his own projections, perceptions and fantasies. If the

analyst provides too much information, she impinges on the patient's experience and something is lost[5]. In the analyst's gesture of disclosure, she shows the patient that it is safe enough to take a risk.

Cooper writes about the analyst's communication of her beliefs in psychic possibility. He notes; "Something is being conveyed about the possibility of acceptance and bearing experience" (p.176). This "something" may be the analyst's trust in the analytic process and relationship between self and patient. Cooper maintains that this type of communication is not just about indicating to the patient what she is capable of, but also what she cannot do -- where she has little influence over change. Cooper builds a case for hope that is not only about changes that can occur, but also about revising expectations and subsequently tolerating of one's limitations.

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[5] Winnicott's (1960) use of the term *impingement* describes the mother's tendency to interrupt the child's potential for healthy growth, and forcing him to separate abruptly from the continuity of his "going-on-being." Impingement can take the form of the parent's forcing the child to deal with stresses beyond his developmental capability, or if the parent is too intrusive or too absent and allows for frustration to build. Winnicott writes that the child is "wrenched from his quiescent state and forced to respond . . . and to mold himself to what is provided for him… Out of necessity he becomes prematurely and compulsively attuned to the claims of others. . . . He loses touch with his own spontaneous needs and gestures . . . [and develops] a false self on a compliant basis."

The analyst decides what the patient can bear based on cumulative information about the patient, as well as conscious and unconscious internalizations within herself. The analyst considers if the patient is ready for a particular interpretation. The analyst may be afraid that an intervention can cause harm or have no impact at all. Many factors are weighed and measured as the analyst decides her interventions. With this said, if the analyst has not been able to work through her own disillusionment and failures to have faith, she may doubt her effectiveness or usefulness in her role as a catalyst for change.

Cooper suggests that one of the most valuable aspects of analysis for the patient is an acknowledgment of the limitations of the method. Put plainly, "From my point of view, these 'limitations' of analysis are actually part of what we have to offer-something about helping people both to bear increased psychic possibility (when it is defensively averted) as well as to grieve and mourn limitation" (p.222).

When the analyst loses sight of the realistic possibilities of treatment, she runs the risk of latching on to a fantastical version of hope. By engaging in "pathological hope or ambition"(Cooper?, p.222) by maintaining a fantasy that analysis will change and cure

everything, the patient's own magical and omnipotent thoughts are supported. Instead, when the analyst acknowledges limitations of analytic work, as well as its possibilities, then a healthy hope or faith can emerge from the process.

***Peter Shabad***

In Peter Shabad's Despair and the Return of Hope (2002). The author similarly suggests that the process of mourning creates a fertile ground for hope and personal truth. Like Cooper, Shabad relates how patients move from disillusionment and despair, mourning and loss, and ultimately are able to conjure hope. The absence of hope is a result of "unmourned experiences of helplessness and disavowed desire, which turn into passive fatalism" (p. 25). This relates to faith, in that the acceptance of loss leads to a rebirth, allowing a space in which faith can develop. Shabad also holds that the clinician and the patient need to mourn what cannot be remedied or replaced. In this way, Shabad carries forward Cooper's ideas about addressing the limits of treatment.

***Faith and Not Knowing: Salman Akhtar, Nina Coltart and Jeremy Safran***

***Salman Ahktar***

The process of developing faith in the analytic process begins in one's training. Salman Akhtar (2006) recently presented a paper to psychiatry residents on the issue of training and faith. Akhtar describes a process whereby novice clinicians move from "hesitancy" to "conviction" about their trust in the analytic process. In order to make that transition, they have to rely on what Ahktar calls a "borrowed faith" about the usefulness of psychotherapy. Beginning clinicians often have aspirations and idealized views of the psychoanalytic process, but the challenges that they are faced with can puncture these beliefs. In place of the overinflated or newly deflated view of psychoanalysis, the training analyst begins to incorporate a more realistic view. This is faith which is passed down from institution to individual. Ahktar contends that this "borrowed faith" is what a training program has to offer its students.

Akhtar outlines nine educational experiences that sustain students through their initial stages of doubt —or "hesitancy." The are as follows; Being exposed to faculty

members who believe in and practice psychotherapy, reading papers in which cases are described and symptoms are resolved using psychotherapy, reading studies in the peer-reviewed literature that demonstrate the efficacy of psychotherapy, seeing faculty members conduct psychodynamic interviews at an initial evaluation, hearing faculty members discuss their own psychotherapy cases in detail, seeing faculty members treat patients on an ongoing basis, participating in an experiential group along with fellow residents, being treated in a personal psychotherapy or psychoanalysis and being a member of an organization that believes in psychotherapy.

***Nina Coltart***

Nina Coltart writes explicitly about the question of faith in psychoanalysis in her poetic article "Slouching Towards Bethlehem… Or Thinking the Unthinkable in Psychoanalysis" (1995). Exploring the analyst's relationship to faith and its impact on the work, Coltart develops an optimistic metaphor for psychoanalysis that is focused on the process of collapse and the possibility of healing. She acknowledges that analysts do not know what they are doing, not because they are not skilled or trained, but because their work is fundamentally a mystery.

No matter how much the analyst knows, the terrain is ever changing. The dynamic nature of the human unconscious always leads to unknown places. As excerpted earlier in this paper, Coltart writes:

> However much we gain confidence, refine our technique, decide more creatively when and how and what to interpret, each hour with each patient is also in its way an act of faith; faith in ourselves, in the process and faith in the secret, unknown, unthinkable things in our patients which, in the space which is the analysis, are slouching towards the time when their hour comes round at last. (1995, p.3)

W. Bion's work has influenced Coltart, especially Bion's assertion that to tolerate the act of faith is the most difficult and tenuous role of the analyst. Bion acknowledges that the act of faith is strange to scientific procedure and distinguishes it from religious faith. For Bion, the crux of the act of faith for the analyst is to abstain from working with memory or desire. In *Attention and Interpretation* (1963), Bion writes:

> It may be wondered what frame of mind is welcome if desires and memory are not. A term that would express approximately what I need to express is 'faith'—faith that there is an ultimate reality and truth-the unknown, unknowable, 'formless infinite.' This must be believed of every object of which the personality can be aware. (p.31)

In psychoanalysis, things that appear meaningless, fragments of thoughts and behaviors, are attended to and communicated back to the patient. This particular "form of

attention" allows for a freedom and space for possibility to develop. Bion continues:

> If [the analyst's] mind is preoccupied with what is or is not said, or with what he does or does not hope, it means that he cannot allow the experience to obtrude… No one who denudes himself of memory and desire, and of all those elements of sense impression ordinarily present, can have any doubt of the reality of the psychoanalytical experience which remains ineffable. (p.35)

In this, Bion emphasizes the importance of curiosity, active thinking and openness to surprise. Like the child who is eager to play freely and engage her imagination, so should the analyst allow for thoughts, associations and unfamiliar experiences to enter her consciousness.

Coltart suggests that faith in analytic work is what girds the analyst for the hours of not knowing, the ability to sit with patients without really knowing where they are or where the work will lead and to "carry [them] through the obfuscating darkness of resistance, complex defense and the sheer unconsciousness if the unconscious" (p.3). As patient and analyst move even deeper into the treatment, they also move deeper into the unconscious. This is the terrain that is has fewer markers, rules and organizing reminders.

Psychoanalysis, unlike psychotherapy, focuses on the not knowing and on the willingness to be open to the

"emergence of the unexpected" (Bion, 1963). In psychotherapy it may be constructive and supportive to get on a particular track, while with an analytic patient more can be learned "in the working towards a deeper nexus of feeling, fantasy and wordless form… that is slouching towards an unthinkable form" (Coltart, p.3). Analysis demands a greater tolerance of ambiguous experience.

In psychoanalysis, there is a delicate balance between technique, theory and knowledge of human nature. Coltart notes, as does Bion, that the crucial development of technique hinges on paradox. She points to a "grim stage" in the analyst's development when she is jeopardized and restrained by theory and teachers. As a result, the analyst may "detect the faint shuffle of the slouching beast" (p.4) of Yeat's poem *The Second Coming*, and make a premature interpretation. For the analyst to point to a thought or an unarticulated experience before it is fully formed is of little value to the patient. Faith makes possible the waiting and the enduring, the knowing that there will be the right time. To act too quickly may cause "the beast" to retreat back into darkness, but faith will buoy the analyst to believe it will surface again. Coltart's vision of faith here is quite different from Cooper's idea of possibility, in that Cooper suggests that

though the right time will surface, the analyst must trust her instinct and use it as a tool to respond in the moment, even if she is fearful. Coltart, on the other hand, suggests that faith is the phenomenon that provides the analyst with patience and knowing that the right time "will come round" (p.1).

Coltart calls for a merging of intuition and skill within the field of psychoanalysis. She points out that critics attack intuition for being unscientific and that what is examined is, at most, "probable." Analysts depend on faith, which is "supported by rational and imaginative conjecture" (p.5). Though faith may feel like "a spontaneous regression to complete unknowing" (p.7), it is an extremely valuable experience for the analyst. Coltart suggests that this unknowing is closely tied to dread for the analyst. It is terrifying to fly without a net. Coltart quotes Bion: "Such depths of ignorance are difficult to dare contemplate, though I am bound to feel a wish to believe how Godlike I am, how intelligent as a change from being appalled by my ignorance" (p. 9). Again, the acknowledgment of one's limitations may in fact be a vital tool used by the analyst.

Coltart writes about how faith develops for her, within a treatment. She notes that the first year is spent

feeling around for "transferences, history taking and first aid" (p.10). The next stage, when "the darkness closes in," leaves both the analyst and patient in turmoil as they move from the known to the unknown. This darkness is filled with anxiety and excitement. And slowly, faith is fully deployed, non-thinking occurs and "[one's] listening ear is directly connected with [her] tongue and speech"(p.12). A central aim of my proposed research is to flesh out idea of faith developing for the analyst.

***Jeremy Safran***

Bion's theories are central to Jeremy Safran's paper "Faith, Despair, Will and the Paradox of Acceptance" (2000). Safran suggests that there is a similarity between analysts' faith and Bion's understanding of the nature of faith[6]. Where Safran diverges in his thinking is in understanding Bion's encouragement of "unknowing" faith and his conceptualization of the analyst's containment of the

[6] In his writing, Safran implies that Bion's idea of containment acts as an impediment to the analyst's presence in the session. I would argue that Bion on the contrary addresses the issue of containment as a way to be *more* present, open and aware of both his and the patient's experience. Through the process of projective identification, the patient places "beta" elements--unformulated feelings and experiences--into the analyst. While the analyst may be disturbed by this encounter, he works to stay with the patient and transforms the beta elements into symbolized thoughts which he gives it back to the patient. This complex process of containment holds tremendous therapeutic value for the patient.

patient's painful feelings. Safran suggests that as the analyst acts as a "container" for negative projections, he is immediately protected from and lifted out of the immediacy of the therapeutic relationship. When this occurs, the analyst is distanced from "lived experience" (p. 7), thus inhibiting the possibility of mutual encounter between patient and analyst. Safran proposes that the analyst may distance herself from the immediacy of the session as protection from her own feelings of despair and fear. In doing this, she misses an essential therapeutic engagement with the patient. Safran suggests that in order for the analyst to tolerate the patient's bitterness, she must be able to tolerate her own feelings of despair.

He lays out the analyst's despair on two levels. The first level is marked by the analyst's familiarity with working with hopelessness in his own life and the development of some degree of compassion for himself. Knowledge and fluency enable the analyst to experience "empathic resonance" (p. 7). If the language of personal despair is foreign to the analyst, he runs the risk of retreating into a world of empty interpretation and insincere empathy. The second level is characterized by the analyst's ability to develop tolerance for his "impotence as a helper and his inability to solve patient's

problems for them to take their pain away" (p.8). Once the analyst recognizes his limitations, the focus shifts in the treatment. Similar to Mitchell and Cooper, Safran acknowledges that the patient's and analyst's hope and faith are inspired by the acceptance of the limitations imposed by reality. Safran's idea rests on the notion that that the patient sees the analyst as a model—one who can tolerate reality and still have hope.

Safran defines and differentiates between the terms "will" and "willfulness" (2000, p.19). Willfulness emerges from a feeling of despair and has a contrived quality to it. In some sense, the way the term is used is reminiscent of the idealized and infantile aspects attributed to a particular type of immature hope. Will, on the other hand, involves a basic trust that things will work out. Safran understands will as incorporating trust and an acceptance that disappointment will not be catastrophic. Safran explains that if the individual is able to will, he is more present:

> If one has faith in the future, one can invest more fully in the present moment, knowing that the future will take care of itself. One is thus better able to relate to the present moment as it is, rather than force it to be something it is not. In this same sense, one is better able to relate to the other as a subject, or in Buber's terms, as a Thou, rather than, as an object of one's own needs. (p.22)

When analyst and patient have will, or faith, treatment can become process driven, rather than goal driven. The patient becomes an individual, rather than an object that carries out the analyst's vision as healer. With this "willing," this faith, comes a type of freedom for the analyst, but also a greater risk of disappointment and failure. This understanding of will is similar to the definition of faith I use throughout this work.

Safran, however, clearly differentiates faith from will. He explains that he employs the term faith because it implies something more that an expectation of a positive outcome. He recognizes the paradoxical quality to the concept, as it implies "both a fundamental trust that things will come out all right and a tolerance for not knowing what the final outcome will be or how it will emerge" (p.22). This idea, Buddhist in nature, has been addressed by a number of writers, including Epstein (1994), Eigen (1981), Fromm (1960) and Jung (1958).

## *III. Analytic Tools As An Expression of Faith*

The first part of the literature review addressed theoretical conceptions of faith and hope within the analytic process. Next, I will look at the analytic tools

used by clinicians-- theory, technique, and an understanding of one's role—that are at the heart of psychoanalytic work. More specifically, the tools include the implementation of the analytic framework, maintenance of a therapeutic stance, and important conceptualizations such as transference-countertransference and interpretation. For the purposes of this research, the phrase "analytic tools" will refer to the essential elements that are needed to create an optimal, insight-oriented analysis.

***The Analytic Framework***

The analytic framework or "frame" refers to the parameters required for establishing a psychoanalytic treatment. The frame was developed by Freud as a series of recommendations that set the stage for the development and protection of the transference, which was to be recognized and interpreted. While Freud felt it useful to create such a procedure, he also noted that it was a challenge to mechanize a process that relies on the "plasticity of mental processes" (Freud, 1913, p.123). Regardless of a practitioner's theoretical orientation, the frame remains a focal point of psychoanalytic treatment.

Langs further developed Freud's ideas on the frame by

spelling out the ground rules, which include the analyst's implementation of a stable location, a fixed fee, a specific and set session time, consistent meetings, encouragement of the analysand's free association, the therapist's maintenance of free-floating attention, and the therapist's competence in containing the patient's projective identifications. Additionally, Langs writes about the importance of the therapist's anonymity, patient confidentiality, avoidance of physical contact and the absence of a relationship between the patient and analyst. These features create and maintain the frame, which "proves to be the single most important determinant of the background or the core relationship established between patient and therapist" (p. 303), according to Langs.

The frame essentially becomes a "basic contract" between patient and analyst, by which both parties are protected. For the patient, a sense of safety, consistency and containment is communicated through the implementation of these rules, which allows the unconscious process to emerge. For the analyst, the boundaries imposed by the frame take into account and protect her wishes and fears. She can rely on the frame to shield her from acting on her hateful, loving, needy or erotic feeling towards the patient. The frame does not eradicate these experiences

within the analyst, but rather it serves as a tool to contain them and allow for reflection.

One way the analyst exhibits her faith in and dedication towards the analytic method is by keeping the frame and interpreting its break down. Furthermore, Langs maintains that the analyst's ability to keep the therapeutic environment and relationship safe is based on the "analyst's capacity to tolerate painful insights and to deal interpretively with the patient's communicated unconscious perceptions and fantasies, whatever the nature. It reflects the therapist's commitment to the cure through understanding rather than action discharge"( p. 327).

***Transference/Countertransference***

Transference, a complex and important concept in psychoanalytic thinking, was introduced by Freud in his Technique Papers and has subsequently been elaborated on extensively as the field of psychoanalysis has matured. For the purpose of this study, only a basic overview of the concept is necessary. In his work about transference and transference neuroses (1912, 1913), Freud described the patient's unconscious aggressive and erotic feelings as being reassigned from the original object relationship and projected onto the present one. He wrote "The first loving

and hating is a transference of auto-erotic pleasant and unpleasant feelings onto the objects that evoke these feelings … the first object-love and the first object-hate are, so to speak, primordial transference" (1912, p.X).

Transference is the basis of all relationships, but is especially meaningful in the context of the analytic situation, where conflicts appear magnified based on the constraints imposed by the frame. Gay writes that "In every analytic treatment there arises, without the physician's agency, an intense emotional relationship between the patient and the analyst that is not accounted for by the actual situation" (1989, p.204). The patient feels "as-if" the analyst were the source of his projections. The analyst and the patient work to tease apart the "as-if" qualities of the transference from the "reality" of the relationship. An important skill that the analyst brings to a treatment is her ability and responsibility in realizing that the patient's feelings about her are to be considered in their symbolic form. In terms of faith in the analytic process, there are sure to be moments in treatment in which the analyst is tempted to speak to the reality of her own character— to defend herself —but this would pull her out of her role as analyst. Faith in the

process and its principles help the analyst resist this temptation.

The analyst makes the transference conscious to the patient through interpretation, which ideally leads to resolution. The analyst works to show the patient the ways that she is unconsciously motivated in any situation. Implicit in the analysis of transference is the analyst's ability to contain, manage, explore and interpret.

Countertransference is yet another analytic tool. There is great variability of opinion among the classic and contemporary articles that address countertransference theory. Moore and Fine (1990), define countertransference as "a situation in which the analyst's feeling's and attitudes toward the patient are derived from earlier situations in the analyst's life that have been displaced onto the patient" (p.47). Other theorists conceptualize countertransference as the analyst's and analysand's reaction to one another. In his introduction to The Essential Papers on Countertransference (1988), Benjamin Wolstein traces the development of thought regarding this phenomenon. As analysts began to shift and see the experience of transference within the analytic setting in the 1920's, he explains, the issue of resistance arose. The idea of defense or "character armor" shone a light on

"the personal psychology of the psychoanalyst against whom the resistance was offered " (p.14). From here, attention turned to the interconnected aspects of transference and countertransference. With this, the concepts of the analyst's subjectivity and emotional experience are brought to the fore.

In Racker's classic paper on countertransference (1953), he advances the understanding and use of countertransference by arguing that it provides helpful and important data that can be used in an analytic treatment. The analyst's reactions may provide clues to the ego states of the patient. Racker suggests that the analyst's reactions to the patient are either empathic responses to the patient's id or ego or a reaction to containing unwanted parts of the patient's self.

Some of the most vital work of an analysis occurs from impasses (Mitchell, 1993) and ruptures (Safran, 1999). As Mitchell points out, in the analyst's attempt to understand a stalemate, much work can be done in the countertransference. He writes:

> By finding again and redefining his own realistic sense of hope, the analyst is more able to find a voice in which to speak to the patient that is different from the voices of the patient's past, offering their perpetually enticing and disappointing sense of false promise. (p.214)

How countertransference is used by the analyst is a source of debate. Some theorists believe that information about the analyst clouds and overshadow the patient's experience. Others hold that regardless of what is made explicit, unconscious communication is occurring anyway. In fact, the analyst's vulnerabilities are seen by some as strengths. Christopher Bollas (1987) suggests that the patient "make the analyst go somewhat mad" so the patient can "believe in his analysis and know that the analyst has been where he has been and has survived and emerged intact" (p. 254). Further readings in this area include the Aron (1992), Cooper (2002), Gill (1983), Hoffman (1983) and Renik (1998).

***Interpretation***

The analyst puts herself at risk, when she enters the emotional field of the analysis. The idea that the analyst exposes her "self" through interpretation and interactions with the patient is widely accepted (Gill [1982], Cooper [2002], Renik [1995]). Aron (1992) cites a Winnicottian metaphor that elaborates some ideas about interpretation. In 1941, Winnicott used a spatula in evaluations of young children. He watched the infant's range of responses as she reached for the new found object: glancing furiously at

mother and analyst, sucking, throwing, and playing with the spatula. The spatula is a metaphor for interpretation: the analyst gives an interpretation to the patient, and then must sit back and watch how it is used, understood, or rejected. The analyst must have faith that her words will be used to in the service of helping the patient. The analyst hands over the "spatula"—her ideas—and shares ownership of his observations and thoughts.

In further developing this idea, Ogden conceives of the analytic process as one that includes the analytic third. Ogden (1999) conceptualizes it as

> a third subject, unconsciously co-created by analyst and analysand, which seems to take on a life of its own in the interpersonal field between analyst and patient. This third subject stands in dialectical tension with the separate, individual subjectivities of analyst and analysand in such a way that the individual subjectivities and the third create, negate, and preserve one another. (p.62)

Here, the interconnection between the subjectivity of the analyst and the analysand remains intact, but it also produces this other dimension. Like Winnicott's spatula, once the patient gets hold of the analyst's ideas, they belong to neither of them individually but rather to this analytic third. In both Winnicott's and Ogden's conceptualizations, the analyst must feel supported enough by her own beliefs that she can allow herself and her ideas

to be used by another. Ogden goes onto suggest that once the analytic third gives life to an experience, it becomes common property to be analyzed or not (date, page). Either way, it has a presence.

Similarly, in order for the analyst to be receptive to the patient's unconscious, he must create conditions that promote "reverie" (Ogden, 1995, p. 109). Like Bion's working in the absence of "memory or desire" or Freud's "evenly suspended attention "(1912, p.111), Ogden's "reverie" suggests the analyst make himself vulnerable, to allow a playful space to develop to foster the emergence of the patient's unconscious.

***The Therapeutic Stance***

> The therapeutic stance, like other analytic tools, has been reinterpreted and reconsidered as the field has developed. Whether the analyst works from an active, supportive and empathic stance or a more neutral position, the common factor is that the analyst's position is one that encourages and protects the transference.

While there is no one view that dictates thinking about how the therapeutic stance should be actualized, there is consensus that analyst's position ought to promote and encourage self-reflection and curiosity within the patient. This position is a "role" in which the analyst regulates his

own character and exhibits a pattern of behaviors that communicates fairness to the patient.

In "The Analytic Attitude" , Roy Schaefer writes about what the analyst can offer (1982). He posits that, "For the analyst, analyzing is not an alternative to being helpful, it is the analytic way of being helpful" (p.8). The components of the "analytic way of being helpful" include the analyst's curiosity, empathy and neutrality. The analyst's goal is not to make judgments about the patient's life, but rather to promote inquisitiveness within the patient.

Schaefer's ideas on the analytic attitude emphasize that the analyst must remain neutral in relation to the material presented by the patient. He suggests that the analyst should not side with the id, ego or superego. "The analyst has no favorites and is not judgmental," he avers (p.5). Additionally, the analyst should work to hold in mind the multiple and contradictory meanings of a patient's communication. He must be able to tolerate ambivalent thinking and needs to stay away from "either/or thinking" (p.10). The analytic attitude also includes the power of analysis—the use of interpretation and clarification guided by attentiveness, careful listening and good timing.

## *IV. Analysts Relationship to Their Work*

Who the analyst is in her personal life and professional life has bearing on her relationship to her work. Although the patient may hold the analyst up as a savior or parent, the analyst also runs the risk of being demoted to the role of seducer, enemy or nuisance. Either way, the reality is that the analyst, like the patient, "is a work in progress" (Agger, 2001, p.315). For that reason, we wonder: how the analyst influenced by her work? The analyst's faith in the analytic process and in herself are likely to be expressed in her career choice.

As the analyst evolves, her experiences continue color her view of her work. A collection of writings on this topic, How the Analyst's Work Shapes the Analyst I & II, edited by Agger and Lichtenberg (1993), explores the ways in which the analyst's subjectivity is inextricably linked to her work. The loop of influence between the analyst's and analysand's subjectivity is a complicated process. For some, the interaction with the patient stimulates responses within the analyst. And for others, "the awakening of sleeping tigers is not a welcome prospect… it can lead to confusion, uncertainty and turmoil" (Jacobs,2000, p. 316). Other theorists, like Moraitis (1993), suggest that the analytic work does not shape the analyst, but rather the

analyst shapes the work, in order to accommodate her own needs and limitations (p. 335). What is useful for this research is that this body theory complicates our understanding of the analytic work and has an impact on the analyst's faith in the process.

The analyst's own analysis is another area that shapes on the practitioner's faith in his work. In a recent book, The Analyst's Analyst Within (2003), Tessman highlights one of the features of psychoanalytic training that differentiates it from most other professions—the rare requirement of practitioner to experience being a patient. The psychoanalytic candidate is required to undergo psychoanalysis. This allows the student to develop a unique and intense relationship to her career and her role as an analyst. (By contrast, medical doctor need not undergo an appendectomy as a condition of performing one.) Is an analyst's faith in her work based on her personal experiences of psychoanalysis? Tessman cites numerous studies that have confirmed that transferences and mental representations of the analyst (in this case the training analyst) remain alive and can be a resource in inner life (p.311).

The evolving identity as an analyst is based on many things, but the personal training that is at the center of

psychoanalytic training is vital. Silber (1996) notes that "For the analyst to work effectively, to enjoy and believe in his work, his own analytic experience has to have been fulfilling and convincing in both a personal and professional sense" (p. 532). Theories suggest that identification with one's own analyst and her functions are the foundations for one's own analytic abilities. (This parallels the idea that good identifications with parents inform healthy development.) While there are many examples of healthy training analyses, there are also cases of the inverse: resilient analysts who endured damaging or disappointing relationships in their personal analysis. Finally, the analyst's faith in the process is shaped by her own life history and private life. According to Gerson, "How we make clinical use of what we have fashioned from our life encounters is of importance. Personal struggle with crises or with certain aspects of identity sometimes enhance, sometimes limit, but always affect our clinical work." (1996, p.xiii). Over an extended period of time, the analyst's commitment and trust in her work may be influenced by similar situations.

### *Summary of Literature Review*

The first two sections of the literature review build a case for the discussion of faith in psychoanalysis by looking at the theoretical predecessors of this topic. The examination begins with the ideas of Hans Loewald, as his writings provide the groundwork for faith by introducing the concept of the patient's potential and the analyst's skill in locating and employing that potential. Following along these lines, Sandra Buechler develops even more fully the ways that the analyst acts as an agent for change in the analytic situation. She notes that the analyst's own hopes and own relationship to challenges and difficulty are an integral part of and communication to the patient.

In a more explicit discussion of hope and the loss of it, the writings of Stephen Mitchell and Steven Cooper are examined. These writers share a respect for the experience of hope and dread in both the patient and the analyst. Mitchell and Cooper feel that there are beneficial qualities in the loss of hope and suggest that a creative and productive piece can come out of doubt. When the analyst is confronted with doubt and dread, she is consciously compelled to address her beliefs in the analytic process, and tries to imagine what is possible and what is not. Through the analyst's reflections and acknowledgment of struggle, a kind of hope can be rekindled. As these writers

suggest, doubt is not an end product but rather an opportunity that engages questioning and a new perspective on what is possible. It is this rebirth of hope that I propose is actually the engagement of faith.

In treating hope and doubt as the major components of the process of faith, the literature review continues to address theoretical ideas that speak directly to the matter of faith. Nina Coltart explores the analyst's relationship to faith by focusing on the process of collapse and the possibility of healing. She acknowledges that analysts do not know what they are doing, not because they are not skilled or trained, but because their work is fundamentally a mystery. The dynamic nature of the human unconscious always leads to unknown places. She contends that the deeper the analyst travels into the patient's unconscious, the more faith she must have. Similarly, Jeremy Safran emphasizes the centrality of ambiguity and not knowing as part of the analytic process. He suggests that for the analyst to be able to tolerate the patient's fears, she must be able to endure her own feelings of despair.

Finally, Salman Ahktar's recent paper lays out the developmental steps the training analyst goes through to tolerate her doubts until she integrates faith into her own belief system. Ahktar suggests that novice clinicians' rely

on the beliefs of senior colleagues and institutions until faith becomes internalized. He argues that the transmission of faith is one of the most valuable things a training program can offer its students.

The third literature domain outlines various analytic tools, as these are the concepts and apparatus that differentiate psychoanalysis from other therapies. For the purpose of this research these tools include transference, interpretation, the analytic framework and the therapeutic stance. An understanding of these analytic tools are important because their application and effectiveness are influenced by the analyst's faith in their efficacy.

The fourth and final domain addresses the analyst's relationship to her work. Publications that address the impact of the analyst's experience of being psychoanalyzed, her relationship to her work and her life experiences are reviewed. The analyst's evolving identity and faith in psychoanalysis interact with one another and are therefore significant.

## *Methodology*

The purpose of this research is to explore psychoanalysts' faith in the analytic process. I collected data by asking ten analysts to reflect on their professional and personal experiences and discuss the ways in which their beliefs and doubts in the analytic process have had an impact on their professional work.

The universal nature of clinician's faith in psychoanalysis is explicated through an examination of themes that are shared amongst subjects. By looking at the pattern of themes that emerged from subject's narratives, one can see the shared experiences , as well as divergent ones. In complement, an evaluation of individual interview vignettes will highlight the idiosyncratic dimensions of faith. This gives an even more detailed study of the interviews and shows the aforementioned themes in context-- how they are worded, experienced and described by the clinicians. By looking at the data from both a macro- and microscopic view, the richness and complexity of faith is brought to life in a whole, balanced way.

Rationale for the Design and Method

In order to explore analysts' personal definitions of faith and the implications of those definitions, I needed an open and flexible methodological approach. Qualitative research was the most appropriate method for this study because it enabled first-person descriptions of the participants' experiences and insight as they have evolved over the course of their careers and their lives. The research was conducted with the intention of understanding how psychoanalysts define and experience successes and crises in their work, and how their faith in the analytic method informs their clinical choices. The theoretical and subjective qualities of the topic required flexible inquiry and discussion. I drafted an interview protocol and initiated a pilot study to test it. The original interview protocol was slightly more structured than the final version and required the participants to answer many more questions. The pilot study included psychoanalysts, psychodynamically-oriented psychotherapists and a doctoral student, all with at least seven years clinical experience. Four subjects were interviewed two times, with two weeks in between face-to-face meetings, which were held in their private offices.

Issues arose in the pilot interviews that indicated that a fixed and linear inquiry was not the most conducive way to organically explore this topic. In order to establish rapport with the participants and create a "relaxed" environment, I expanded the process to include queries about clinical material when appropriate. This allowed subjects to think about and discuss clinical experiences and personal beliefs in their own terms. As a result, the current interview has both "required" questions across participants, and also informal prompts and clarifying questions used at my discretion to elicit additional information and allow the subjects to expand on topics of interest.

The first interview was the semi-structured portion, and the second interview (usually done within 14 days of the first meeting) provided a chance for subjects, having reflected on the topic, to talk in greater depth about the clinical examples they had provided and to add new ones. This reflection was useful because it allowed the subjects to express conscious and unconscious reactions to the topic of faith in psychoanalytic work. Faith is not always front and center in our consciousness.

Two of the pilot subjects discussed the concepts of "faith," but used different words, including hope and trust.

In order to maintain my connection to the participant, the rhythm of the interview, and also because these were the terms most meaningful to them, their terms were used. When this occurred, I added questions to the interview to explore these terms and to get as accurate a definition as possible.

## Participants

The ten study participants were all psychoanalysts who have private practices in New York City. (These subjects were different from the pilot interview subjects). They ranged in age from 45 to 67 years. Their experience ranged from nine years as an analyst to 38 years as an analyst. Eight of the subjects were supervising analysts at various institutes. Four subjects teach psychoanalytic theory at the graduate level. Five were women, and five were men.

While all of the subjects interviewed for this study are psychoanalysts, nine of them were trained as clinical psychologists and one as a psychiatrist. All work with adult patients, and three also work with children. The clinical cases discussed in the interviews, however, were individual adult treatments.

Participants received their analytic training from various institutes, including New York University Postdoctoral Program , New York Psychoanalytic Society &

Institute, Institute for Psychoanalytic Training & Research (IPTAR), The William Alanson White Institute, and The New York Freudian Society. Three of the participating analysts specified their theoretical orientation as Neo-Freudian, two as Interpersonal, two as Relational, two as Neo-Kleinians and one identified as Intersubjective.

Research Materials

The primary instrument for this study was the semi-structured interview devised by the principal investigator based on a review of the literature and tested in the pilot study (See Appendix A). Most questions were open-ended, as suggested by McCracken (1988), so that participants could be as free as possible to answer in an unstructured manner. The questions were similar, but with some modification, to those posed in the pilot interviews. Interviews generally lasted between 1 1/2 and 2 hours.

The interview questions were thoughtfully developed as a framework for conducting the research and to ensure that the interviewer would cover essential areas in each interview. The structure of the interview moves from general, overarching questions to more specific and personal questions. The interviewer also used spontaneous probes as

necessary to elicit additional information about cases. The following topics were covered by the interview protocol:

1) Biographical data about the participant and his training. This also established an initial rapport with the participant.

2) Faith and hope as components of the analytic process. This question is meant to engage the participant and allow him to enter the subject in a spontaneous and personal way. By asking about hope, an opportunity becomes available to discern differences in the participant's definitions of these concepts.

3) Personal definitions of faith and hope and elicitation of clinical vignettes that support these concepts.

4) The participant's own sense of hopelessness that may enter analytic work and clinical vignettes involving crises of faith.

5) The effects of personal factors on the participant's beliefs in his work, including the influence of his training analysis and personal struggles.

6) The technical implications and theoretical frameworks which relate to this topic.

7) Definitions of faith and hope are revisited at the end of the second interview as well, to see if new associations or ideas emerge after consciously thinking about the topic.

8) The participant's reactions to the research study.

Procedures

Subjects were recruited by word of mouth. Colleagues, supervisors, professors and study subjects contacted analysts who were interested in discussing the topic of faith in the analytic process. Contact information was then provided to the principal investigator, and initial contact was made by phone.

As noted above, ten subjects were recruited for this study. Subjects were initially scheduled for a single interview session, lasting approximately 1 1/2 hours, during which data was collected via audiotape. The principal investigator also took notes during and after the interviews that were relevant to both process and content. Interviews were held in the analysts' private offices. Over half of the subjects were scheduled for a second follow-up interview based on the amount of material covered in the first session. The interviews elicited responses including answers to open-ended questions and spontaneous narratives.

Privacy and confidentiality were vital for the subjects. Protective measures were laid out in a letter and then were verbally reiterated at the beginning of the interview. Tapes were transcribed and labeled with identification numbers. They were stored in a location separate from demographic information about the individuals. Participants' names and references to their patients were not used on the audiotape. Tapes were double-checked to make sure they had no identifying data on them. In case a masked reference was recorded, it was obscured in the transcription.

Interview Process

Analysts agreed to participate in this study because they had strong beliefs in their work and valued an opportunity to reflect on it. It seemed that the analysts did not necessarily have many opportunities to discuss in depth the intricacies of their work and were excited by the time spent reflecting on their clinical experiences. In addition, subjects voiced eager support of graduate research.

Overall, analysts seemed engaged in the interview process. A few of the subjects appeared guarded at first, wondering how the clinical examples would be used and if they would be identified. After an initial rapport was established, the subjects seemed at ease discussing clinical material, as well as their struggles in their personal analyses, difficult life experiences and professional challenges.

One interesting phenomenon, which emerged in at least half the interviews, was that analysts talked about their work in transcendent terms. Many of them were self-conscious that they would sound “pollyannish” or “weird,” but many described a cognitive and affective experience of something “beautiful” and “rare” that occurs in a therapeutic, human interaction.

Many of the subjects appeared more relaxed during the second interview. A number of the analysts said that they had thought about the questions asked during the first round and wished to elaborate on certain responses. Most of the subjects felt that the time spent participating was valuable, in that it provided them a chance to step back from a busy and highly charged work situation.

## Data Analysis

The qualitative research used for this study allowed for patterns and themes to develop from the data, rather than the researcher working to prove preconceived hypotheses. This method allowed for a breadth and depth of information and themes to emerge. In particular, the topic of faith is multidimensional, and a goal of the study is to pick up on the nuances of the issues and to gain a fuller understanding of the subjects' perspectives. The investigator focused on case examples and personal experiences in order to consider the various qualities of the responses to questions. According to Taylor and Bogdan (1984), qualitative methods allow the researcher to empathize and identify with the subjects they study, and I found this was so.

As described above, a pilot study was implemented to assess the usefulness of the queries and to fine-tune outstanding issues. The next phase of the study yielded responses to questions that included rich, personal narratives. The interviews were then transcribed and examined multiple times to uncover themes. The first evaluation of transcripts focused on excavating themes from each subject's narrative. After the individual subjects' themes were examined, a second round of data analysis divided each transcript into meaningful portions. Using core concepts derived from the data, categories of shared themes were constructed. These themes were then compared to one another and examined for similarities and differences.

Narrative data was analyzed using a dual strategy: cross-case analysis and individual-case analysis. The cross-case analyses allowed for universal themes to develop in multiple situations. Data patterns surfaced by comparing and contrasting numerous cases. These convergent ideas suggest that the themes reflect important but seldom acknowledged dimensions of psychoanalysis for analysts and patients. The individual cases are then used to showcase universal themes, but also show in greater detail the idiosyncratic ways they are expressed. This type of data analysis provides focus to detail and captures the unique aspects of a subject's

experience. These two types of data presented are complementary and illustrate a comprehensive picture of analyst's faith in the psychoanalytic process.

The major themes are presented in the following chapter. In addition, excerpts of the interviews were also examined and showcased in the following chapter as a way to show the individual nature of this topic.

# RESULTS

In this chapter, I present the findings that I have reached from a thorough and rigorous analysis of the interview transcripts. The evaluation of transcripts generated a multitude of themes and categories as outlined in the methodology chapter. The themes that developed across subjects underline concepts that were present in all subjects. To further illuminate the specifics of each theme, I present four vignettes. These vignettes were chosen because they represent different positions of the experience of faith, the loss of faith and the effect on treatment. By presenting the data this way, I hope to demonstrate prevalent themes that are experienced and articulated in personal ways.

I summarize the themes that emerged from the narrative data using participant's quotes (which are included in Appendix B). The common themes are organized into six sections as a way to highlight the similarities in subject's responses. The first section illustrates the ways analysts define the concept of faith in the analytic method. Types of clinical experiences that activate analysts' faith and doubts will be presented in the second and third sections. The fourth section will describe professional experiences

other than clinical work that sustain the analyst's faith. In the fifth section, I review analysts' discussions of personal experiences that have had an impact on their faith. The final section will show the implications of faith (or lack thereof) on technique.

In order to provide a rich and thorough view of the data, I use excerpts from four subject's interviews to illustrate the six themes, showing in more detail both the variation and similarities among the analysts interviewed. This part of the study draws on individual aspects of experience and analyzes both conscious and unconscious material.

As with any qualitative study of a phenomenon that is both personal and cultural, there is rich variation among subjects. There is even variation and inconsistencies within individual subjects' narratives. Differences may be due to experience, understanding or presentation. Even so, the subjects' detailed, thoughtful responses to interview questions provided enough material to begin to synthesize collective experiences.

Interview questions were responded to in unique and highly personal ways. As is evident, the study of faith is complicated in that the experience of faith is particular to the individual. This is especially the case in

psychoanalysis, where, I am arguing, faith emerges from intensely personal life experiences, professional doubts, and unique analytic relationships.

## 1. Definitions of Faith in the Analytic Process

Research subjects were oriented to the topic with a general definition of faith in the psychoanalytic process as a positive belief in the future that is tempered by realistic limitations. Some subjects preferred to label the concept as ”hope,” ”confidence,” ”trust” or ”belief.” For instance, one subject describes her ambivalence about the term ”faith” this way: “I’m a little uncomfortable with the word “faith” because it has an implication of church and God and something external for me … I mean I wouldn’t say I don’t believe in God, because I don’t have strong feelings either way… . But I believe in this process and I believe, based on what I understand and how it works for me and others.”

Most of the analysts who were interviewed initially defined, or accepted my definition of faith in the psychoanalytic process as a long-term expectation for positive change (i.e. relief from psychic suffering) based on the patient’s potential to gain insight and awareness. Eight of the ten subjects interviewed introduced their

characterizations of faith in the psychoanalytic process as closely related to seeing the patient's promise for change.

Initially, the subjects' discussions of faith in the psychoanalytic process were constructed in impersonal and intellectualized ways. Most notably, the subjects were other-focused. Their discussion centered on the patient's potential, the patient's hope and the patient's motivation. As one analyst states:

> I think faith in the process is a confidence that a person has the potential to move forward in a way, that's sort of like raising a child, but it's not the same. I think the idea that you have an image of the person that they're going to be or that they have the potential to become sort of guides your pulling them forward developmentally, so I think similarly you know you have to be able to imagine or visualize the patient in some better place.

A parallel theme emerges in another subject's description:

> Early on in most treatments I find myself seeing a place in the patients where they're refusing to allow hope in. And I always interpret it and I always bring it to their attention and it's one of the most powerful shifts in the analysis. So, I think hope plays a central, major and pivotal role, because everyone has a hope, everyone's born with a hope. Once you embrace that, your life is working, and if you can't embrace it, that's pathology, and so I think hope is at the very core of psychoanalysis… I hope in my patients, I hope for them and I see their hopes for them.

Another subject points to the paradox of patients' suffering. Within patients' pain there is resilience, which the analyst finds inspiring:

> Hope is enormous and it shows up in all sorts of ways. I mean, patients don't know it when they come

> to treatment but it's an expression of hope if nothing else. We tend to think about the sort of underside of that, the despair. But I think just the act of the person coming to treatment is hopeful. For the most part, people come to treatment because they're at the end of their rope. But if they were really at the end of their rope they wouldn't be in our office. They're here because they have some faith, some belief that things can be different.

The majority of participants defined faith in relation to hope. A number of them saw faith as an enduring belief, while hope was more ephemeral. One subject said "Faith seems anchored more in a framework of belief. Hope is more transient…kind of if you think of a firefly, rather than a spotlight." Another subject articulated the way that faith may be related to hope, but it is not defined by it. He said: "Maybe there is something about faith that involves not keeping hoping for something else, saying 'this is what we've got.' … What we are talking about, really, are the imperfections of the work."

Many of the analysts reported feeling wary of depending too much on hope – often respecting the constraints imposed by reality. For instance, one participant suggested:

> Some people are too hopeful. Right? Some patients are too hopeful and some analysts are too hopeful and with some patients a lot of the work is about giving up their hope. False hope. Hope for something that never happened earlier in their life or something that's never going to happen. And with some other

> people you have to create a feeling of hope in their lives…

Another subject describes variations on hope in this way:

> You [the analyst] have long-range hopes, but you may not have any hopes for the immediate present in terms of a person's ability to feel better or be able to respond in a way that isn't so painful, or isn't so self destructive. You have the sense that this is a process, and so you say, 'It's not that it's my expectation, but it's my hope that these things that are going on now that seem bereft of hope, are not going to be.' So you have a long range aspiration which is where that hope is. And then you have short range aspirations, and sometimes things feel pretty hopeless. But that doesn't mean that you don't hope that either you or the patient is going to figure a way out.

The majority of subjects also provided a set of responses in defining faith that were highly personal, idiosyncratic and experientially-driven. For example one subject responded in this way:

> The more you have experienced, the more you really trust the process—that it can handle it. I'm not saying it's 100%, you know. There is always a piece of anxiety… I think actually as I do it, as I have been doing it longer, I actually believe in it more. With some patients I feel it is really very strong, and I know it's going to be okay with them. A certain gut feeling that's with me. Of course it is based on how we are together. And with other patients I feel less—it's more like 'we'll see.' I think if I absolutely feel that I can't be of help or if it's clear that I don't have faith for them, or for me with them, I won't work with them.

Another subject also sees faith in psychoanalysis as something that is knowledge derived from experience, rather than acquired by intellectual methods:

> I fear and I delight to think in [sic] the knowledge that it is idiosyncratic and so idiosyncratic to each analyst. Also it is what I think of as auto[bio]graphic—that is particular to each dyad. … I don't know if this is what you mean by faith, but part of my sense about what this process is about is very much a lived-through experience. So what we do with patients, how we are with them, how we behave, I think I believe is critically important. … This is very different than the original perspective on treatment which is what we *say* to patients and what they *say* to us is sort of a separate thing than what we do and what they do. So part of my sense about what makes treatments go is a lot about what's done together not just what's said to one another[…]

## 2. Doubt in the Consultation Room: Clinical Experiences In Which Faith Was Tested

I asked the subjects to enter into a more explicit discussion of faith in the psychoanalytic process by providing clinical examples. I had expected that, based on the number of subjects who underscored the importance of the patient's potential, clinical examples would be filled with situations in which the *patient* overcame challenges. Instead, what I found is that all ten of the subjects responded with clinical experiences in which *they* were tested and challenged. As these descriptions make evident, the subjects' faith in the analytic process is felt to be

contingent upon their own ability to tolerate intense emotional experiences (both the patients' and their own) and disturbing situations which arise in the analytic setting.

Significantly, all ten subjects provided examples in which they were faced with subjectively unbearable situations that tested their faith (see Appendix B, Table 1). These experiences seemed to develop when the therapeutic situation became too intense, too real or too personal for the analyst. It appears that the perceived threat causes a type of psychological collapse that pushes the analyst from the analytic stance. The data reveals three categories in which analysts' faith in the process of psychoanalysis were challenged. They are:

(a) Patient failure: analysts felt a patient was getting worse or on the verge of a psychotic break; they felt bombarded by the patient's rage, despair or hopelessness; or they had to deal with a patient's remoteness. Analysts also described patient's inconsistent attendance or obvious lack of progress that led to stagnancy.

(b) Personal failure: Analysts were confronted with difficulties arising from their personal histories or patients' behaviors. This includes a therapist's feelings of rage and hatred towards a patient, overwhelming self-

doubt, and, in one case, intensely loving feelings towards the patient. Some analysts also felt hopeless in the face of ambiguity or lack of a plan within a treatment.

(c) Poor patient/analyst fit: This involves the relationship between the analyst and patient. For instance, subjects spoke about working with patients whose conflicts touched too directly upon their own unresolved issues. In other cases, the patient and the method were mismatched. Also, some subjects felt their patients were "too sick" and therefore their confidence was affected by fear of patient's self harm. The potential of a patient abruptly abandoning or terminating the treatment also prompted doubt.

Interestingly, analysts who struggled with doubts about their work spoke about the loss of faith in themselves, and instead about a loss of faith in the psychoanalytic endeavor. As one subject noted, "In most instances, the crisis of hope has more to do with personal failure or a countertransference issue that I haven't mastered at the moment, rather than there is something intrinsically wrong with the method." Similarly, another subject said:

> When my faith in the process is shaky? Really the analytic process is intact and if something wasn't working perhaps it wasn't the process itself, but

> rather my participation in it. It becomes a question about my choices and my own abilities to supervise and facilitate the process as an analyst, rather than a question about the process itself.

Importantly, all ten subjects conveyed a deep respect for analytic theory. They described psychoanalytic ideas as "brilliant," "strong," "creative," "adaptable" and "rich." Subjects are not suggesting that they are failed by the theory, but rather by their personal limitations.

## 3) Faith in the Consultation Room: Clinical Experiences in which Faith was Sustained

Faith in the analytic process is linked to the analyst's belief in her patient's potential and/or her ability to endure subjectively unbearable situations. Based on the data from interviews, subjects' faith in the analytic endeavor is heightened by clinical cases in which they feel connected to the patient, identify with the patient or have a history of surviving previous clinical ruptures. These analysts describe feeling effective, productive and gaining some narcissistic reward.

Eight subjects felt most hopeful with patients with whom they could connect (see Appendix B, Table 2). This "connection" takes many forms. One subject provided a rich

example in which she is fond of her patient and strongly identifies with him:

> First of all the patient I am thinking of--he's cute *(laughter).* Maybe because he and I are [the same nationality ] and his father was killed in the war and he's like, you know… I kind of understand very profoundly the family he grew up in, the stresses that were qon his mother, and his siblings, and all that goes into it. I really know it well, and I could very easily see the bullshit that was going on in his family that he really couldn't see. But the minute that he started to talk about the memorial services that were all kind of phony… It was as if you opened up the whole new book for him that he's very, very excited about— it frees him to see his family in a new way for the first time. He was playing a role for such a long time for all of them. … So all of this is … very exciting because I feel I kind of get him, which is nice—it's not every patient that you feel this with. And he kind of gets me, so we've developed a good working relationship, so I feel like, it's working nicely. I'm aware it's still the honeymoon.

Another subject provides an example of connection that occurs on a human level. He says:

> I remember saying to [the patient] and realizing myself, "It's not about any interpretation —it's about my relationship with you—to him. It's about how you treat me, how you relate to me, how you hear me. That's what makes it work. It's not about any magic thing you're going to say to me." And that's profound… someone who's sitting and listening to you and interested in you and caring about you is a healing thing in and of itself, and it's an experience and love that maybe nobody has in some sense, and certainly a lot of patients have never had it, and or had it to that extent, let's put it that way. Those are experiences. You don't know until you've been in therapy, you don't have any sense of what about this process really works.

In a similar vein, five subjects discussed the satisfaction and nourishment they gained from working with patients who were similar to themselves. One said:

> I think the most satisfying are people who I've shared some kind of experience with. People who I feel are like me in some elemental way. Regardless of what happens in their therapy that feels very satisfying for me… I have a patient who's father was Jewish and mother Catholic. My father was Jewish and my mother Catholic. He grew up in Europe, I spent a lot of time growing up in Europe when I was a kid. So when he talks about feeling like he's not in one place or another, I know exactly what he's talking about. I know exactly. He's not, I can't say the, the, the country he's from, but he's not from this country and he's not from that country. I know it. I know what he's talking about and that's satisfying. It's a kind of a connection, you know, that I can't have with everybody.

Four subjects talked about clinical situations in which their faith in the analytic process was sustained because they recalled their abilities to endure harrowing experiences with a patient in the past. In recalling subjectively unbearable situations that they had weathered or tolerated before, subjects found a degree of ego strength. As one subject recounts:

> The first experience I had with a patient who was in analysis and was in very profound regression, and I really felt "I'm kind of losing her," not only as a patient, but that she's totally kind of disintegrating in front of my eyes because of a combination of things that happened in the analysis. I think I was overwhelmed. I think it was about maybe fifteen or sixteen years ago. And I think staying with it, and kind of living through it—with all the hellish situations—did leave me with a sense of faith;

> because, I think maybe years before that I would have given up, or rushed to do something —to go for external help like medication. You know, things that maybe today people are more equipped to do. But I really felt it was extremely important in that particular case to go through it—to go through with the regression and, a la Winnicott, kind of believing then that we'll survive it. The faith is also partly rooted in people like that, who have been through it before, and wrote about it, talked about it, and knowing we can come the other way and really benefit a lot. This patient had this important analysis that really changed her life in a very, very profound way.

Eight subjects spoke about the satisfaction and inspiration they derived from seeing patients change. For example, when the patient expresses her new found "mind" and is able to reflect on her thoughts and actions, she induces hope for the clinician .One subject recounts:

> I had a patient the other day who caught herself in a moment of viscously attacking her boyfriend. And she knew that she totally screwed up. And catching herself in the moment made her feel hopeful. She wasn't despairing, even though she had done something to temporarily cause a problem…She was like 'this is what I do. This is why I do it.'…She got it on a deeper level. And maybe next time she can stop herself even earlier. And there was hope that came out of that.

**4) Faith Elsewhere: Professional Experiences in which Faith was Sustained**

Subjects who were faced with a crisis of faith in their work talked about finding refuge in various locations that offered support and acted as a temporary observing ego (see Table 3). All ten subjects noted that when they were

confronted with intense doubt in the analytic process, they often turned to other professionals in the field for support. One analyst said:

> Some of my faith comes from people who are very experienced, very thoughtful about the analytic process, and very honest, you know about the pains of it. People who are not carried away by the zest for fixing or curing, but respectful for what it takes to be in it, in and out, day after day, with the difficulties – with the pleasures, but a lot with the pains, and part of the pain is really sitting in uncomfortable days… It's extremely hard…

Other types of external support came in the form of peer groups (5 subjects) or supervision (3 subjects.) One analyst stated that "I often think of my beloved supervisor. I can hear her voice, British accent and all, saying 'Courage, my dear. Courage.'" Other support was found in informal processing with colleagues (8 subjects), or by returning to theory and favorite books (3 subjects).

When subjects were not as severely blindsided by their doubts they worked to secure a shaken faith by formulating situations with patients as unconscious interactions and therefore data for treatment. For example, seven of the participants said that it helped them if they viewed an interaction as an enactment, or negative feelings as transference/ countertransference. One subjects describes his experience:

> We weren't making any progress…I wondered if I was missing the boat. Or if she was not as open to the process as I had hoped. But whenever I find myself thinking that way, I stop thinking that way. I realize that this is the there are some analytic treatments that are just difficult, in that they tax your faith and your ability as an analyst. And then when I get on top of my countertransference, I am back in the ballgame.

This "reframing" facilitated the creation of a space necessary to maintain a therapeutic stance. In employing theory, the subjects regained the *experience* of having faith again. But, to use these concepts, the subjects had to have faith in the frame and the process in the first place.

For six of the subjects, experiencing significant doubt and even despair about their work with the patient allowed for a rebirth of belief. It is this crisis or disillusionment that gives way to a new way of thinking. One subject recounted:

> There's this paradoxical dimension to therapy. You have to be real and unreal at the same time… I have a patient who kept asking me, "Do you like me? Do you like me? Do you like me?" And I had this experience of thinking "If you asking me again, the answer is no!" But then I realized that I wasn't being effective for her. I was sitting there and wondering, "What can I do to move this? How can I help her?" In a way, in order to be effective I had to be sent into hate and despair of how we were going to get out of this…. If I didn't have those instances in this work, I would be untouched.

Another subject noted:

> The suicide attempt of my patient influenced my outlook. It was an enormous realization that I can't do this in some half-assed way. If I'm going to do, I have to do it. Or be out of it… I had to surrender to this work. It's a high stakes game.

In both of these cases, the analysts needed to be "touched" in some way. Their countertransference reactions to their cases acted as markers for their engagement in the work. Once these therapists had authentic and painful experiences they became more committed and involved in the analytic process. Renik (1998) writes that the analyst who is able to keep hold of his "realness" in the face of the patient's destructive attempts makes the analytic situation more effective.

Finally, four subjects said they sustained their faith through maintaining a type of self-care, such as adequate fees, adequate vacation and time spent with family. They all felt that they needed to be compensated for their work in order to maintain an empathic position with patients. Low pay and overwork led to analysts feeling "depleted," "resentful" and without compassion.

**5) Lessons of Life: Personal Experience as a Source of Faith**

All of the analysts interviewed indicated that their faith in the analytic process stemmed from their personal

experiences. These experiences varied (see appendix B, Table 4), but an overwhelming majority of subjects believed that years "on the couch" as analysands had a significant impact on their faith (9 subjects). One subject said that his questioning was a consistent part of his analysis:

> I was in analysis for fourteen years so there was ample opportunity — questioning, "What is this? What is it all about? Have I changed? Am I any different?" Many times. And in a certain way the answer to those things come into play here … I think the only [experience] that really matters, to be perfectly honest with you, is your own treatment. I mean, I know there are people who are much more into the theory than I am, and they take a certain faith based on whether the theory makes sense to them. I'm not one of those I have to say honestly. I've never been into the theory. But I think my own analysis had a profound impact on my life.

Subjects said that they felt that their questioning early on has allowed them to tolerate their patient's doubts, as well as their own.

Another subject shared his personal experience about being a patient:

> I was in psychoanalytic psychotherapy for a few years and I think it made things worse for me. It was more supportive than analytic and it impacted my narcissism. Really… and then I switched to a four time a week analysis and it's hard. But I've learned … If there is one lesson I've gotten from my analyst, is that there is one person who is capable of not being a narcissistic, self-involved animal [e.g., the analyst]. My parents were very narcissistic. Knowing this allows the possibility of being able to raise the bar of expectation. I don't want to be used that way. And I want to have more thoughtful interactions with people. That's the model in mind for me.

One analyst pointed to the roots of his belief in psychoanalysis:

> Analysis in some ways saved my life. By the time I went to graduate school, and was conflicted with making that whole decision of whether to go on into X field or not, and when I came to New York I was very depressed and despairing because of that conflict. I couldn't resolve it. And once I came here and entered therapy and analysis—it really did change my life … It's my personal testament—friends, colleagues, my wife, how people speak about their own experience, and their opinion of analysis, and how it changed their life, the depth that it can go to as a transformative experience. And then reading case histories, the traditions, your own training, the work and supervision, the clinical case seminars, just hearing the impact that it has and what a powerful tool it is.

Another subject describes how her own treatment has oriented her in his work with patients:

> There is one pointer that I have consistently with my patients, and that is my own treatment. … It's really hard to stay hopeful with patients when you don't see any changes. I work with eating disordered patients, and that happens a lot… The only way I can stay… I can let go of the expectations and stay hopeful about the process in seeing what happened in my own therapy. It's like that becomes the road map.

Five subjects said that the doubt and questioning of the process that began when they were patients has helped them as clinicians. According to one subject "Part of my faith is from my analysis, and part of my non-faith is from my analysis, you know? Although I understand now things that certainly I couldn't have then."

Four subjects said that recollecting other successful treatments reinforced their faith. One patient said:

> Faith. It's significant. It's important. I don't think I think about it as faith in my everyday work, but when I stop and think about certain points at which maybe I wasn't exactly sure what I was doing, or when I wasn't getting a clear indication of where a particular treatment was going, it was faith, but it was with a mixture of experience. It's not a kind of blind faith. It's really based on my own experience as a patient, as a supervisee, and also my own experience as an analyst, and having been through, for example, a paranoid regression, and knowing that there is light at the end of the tunnel.

Six subjects felt that in identifying with aspects of their patients struggles, they were able to sustain their beliefs. Some said that their faith in working with particular patients was linked to their own similar struggles and ability to overcome them.

Of the five subjects who felt they "knew themselves," trusted "a hunch" or had self-confidence, four expressed having faith in the process. Three additional subjects relied on the sense of personal enrichment they derived from their work to strengthen faith. Three subjects believed that their ability endure difficult situations came from identifications with early objects: two were parents, and one was a childhood friend. Three subjects also mentioned religion or a personal philosophy. One

subject felt unsure of the origins of his faith in the psychoanalytic process.

### 6) **Faith and Doubt: Implications on Technique**

Subjects' responses to interview questions demonstrated that when clinicians began to lose faith in the analytic process, they tended to step out of the treatment in various ways , which in turn exacerbated their doubts. The data revealed that analysts were more likely to relinquish their therapeutic stance or use of analytic tools (for example, by loosening of the frame, having difficulty in maintaining the metaphor of transference and using fewer interpretations about meaning) when overcome by doubt (see Appendix B, Table 5).

Six subjects spoke about aspects of the transference/ countertransference that were affected by crises of faith. Narrative data showed that there were numerous instances in which analysts "believed" their patients' comments about them and lost sight of their transferential role. Similarly, analysts' perspective became clouded when their feelings about patients were not seen as countertransferential responses to the therapeutic interaction. The analyst had difficulty maintaining the metaphorical aspect of the transference/countertransfernce.

There were similar instances in the data in which analyst-as-professional and analyst-as-person became intertwined. This led to the analyst personalizing experiences and working to "correct" a patient's "problems," rather then finding the meaning of them or understanding behaviors as unconscious communications. One subject speaks about the issue this way:

> I mean maintaining my convictions about the meaning of behavior is really helpful because you know I think that if you lose that you can shift too much in the direction of looking at behavior on sort of a surface manifestations. You can really lose confidence in a process like this and I'm sure you know at times it's very troubling that this person isn't present in the office and I'm sitting waiting… there's always blind spots, there are always areas where you don't you know where you become caught up in a kind of sterile resistance, repetitive resistance pattern… It's very important to be engaged in some sort of ongoing self-examination.

Three subjects who viewed themselves as "working analytically" became more directive or supportive when they were confronted by subjectively unbearable situations. Subjects gave examples in which they either referred the patient for a medication consultation or suggested behavioral therapy. Two subjects loosened the analytic frame when they were challenged; one let the patient stay "a bit longer" after difficult sessions, and the other "became more casual, less boundaried." One subject said

she constantly doubted the analytic method, and often used hypnosis, art therapy and other "healing" techniques. Swamped by doubt, another tried to refer a patient out of her practice.

A senior analyst uses a personal anecdote to explain what he sees as the risks and remedies involved in analytic work:

> I had the chutzpah to write Anna Freud. She said, "You're contemplating entering a career in which your personality will be at risk." … I chuckled and though —What does she know about being at risk? I mean, you sit behind a chair and listen to people, and you think you're at risk? So I didn't understand what she was talking about. I had no idea whatsoever, and the way that's germane to your question is that it's not a belief system. What sustains me is my ability to be in touch with what's going on with other people, and with myself… I don't get too wrapped up in immediate gratification with patients. That's where the arena of really getting—you know, your personality being at risk. But I am very connected, and I have watched what happens when you can be connected in that way, and help somebody begin to get a kind of light in what's going on in their own mind. I have joined a kind of sympathy for the pain that's involved in having to do this. Again because I think I closely identify with patients. And that's kind of what makes it helpful —-I mean I don't think you can have empathy if you're not. But they're trial identifications, you know. They're not deep identifications. Internalized identifications. They're trial identifications … Every patient, without exception, brings up continuing conflicts that you either had been able to put aside, or at least had convinced yourself that you had put aside, sometimes years ago. And you need to be able to tolerate that. That's the real threat—it's not, "Oh, I don't work with this kind of patient," or "The last two patients didn't

> do as well in analysis, so I've lost my faith in the process." The thing that I find difficult is the being able to tolerate that level of craziness while another part of your mind is processing it, so it can be brought back into the treatment to use effectively. We see that the use of the frame protects the analyst from the inherent dangers of the work … You <u>are</u> at risk all the time, and you are less able to make the translation into something therapeutic—you get counter transference. This can include, by the way, attempts to make the patient feel not as horrible. Those can include ways of trying to be reassuring just like they can include negative things as well. I think that everybody really has a very rich repertoire of reactions to what patients are experiencing with them.

**<u>Interview Vignettes</u>**

The purpose of the previous section was to bring to the surface mutual themes among psychoanalysts' about faith in the process. This section develops the aforementioned themes --- definitions of faith, clinical examples in which faith is challenged or heightened , sources of and sustenance of one's faith, and the effects of faith on technique.

By examining the data in this way, universal and idiosyncratic aspects of faith are interwoven to create a textured and complex picture. The four interview vignettes are presented in an order that illustrates different positions on faith. In the first example, Dr. B is an analyst who states that he has faith in the process.

Though he is often confronted with challenging scenarios and clinical ambiguity, he maintains the analytic frame. In the case of Dr. A, another type of analyst who also reports to have faith in his work, points to moments of ambivalence, which influence his therapeutic stance. The excerpts from the interview reveals incidents in which Dr. A's confidence in his clinical choices wavers. In the next case, Dr. S, faith and doubts are volleyed back and forth. Dr. S discusses challenges in which she is tested by her patient. As the interview shows, Dr. S reports a deep commitment to her work, although she toyed with leaving the profession less that a year earlier. Finally, Dr. J is an analyst who asserts to have little faith in the analytic process. Her use of certain analytic concepts and techniques clouds the issue of her faith or its absence.

**Dr. B.**

Dr. B, a 44 year-old psychoanalyst, has a full-time psychoanalytically-oriented practice in Greenwich Village. He supervises for two graduate programs and two psychoanalytic postdoctoral programs. He has been in private practice for 16 years, 12 of them as a psychoanalyst. He identifies his theoretical orientation as Relational-Psychoanalytic. Dr. B agreed to participate

in this study because of his own philosophical interests and commitment to psychoanalysis.

When I first met with Dr. B, he had already given thought to the topic of faith in the psychoanalytic process. At the outset, he talked about faith in the psychoanalytic process as an important intellectual concept with which to wrestle. He said:

> It feels to me like faith in the psychoanalytic process is a lot like democracy in that the analytic process is an imperfect and kind of problematic mode of engagement. That we're always trying to make more ideal and we're always trying to strive to make fairer, to make more just, to make more sense, to kind of move ahead in a of progressive direction. And so the way I've approached psychotherapy and psychoanalysis has been to engage the faith in the process, in a kind of problematic way with a positive benefit to that. To consider faith to be a kind of problematic concept. And as far as I'm concerned the more that you're in engaged in that problem, the more faith you have.

He went on to say, " Faith seems to me like something you can struggle with and something you can question and something that you really can use in certain ways. Hope seems to me more one-dimensional. Like you either have it, or you don't have it or it's either justified or not justified or… it just seems a little less… I don't know what the word is… sturdy?"

In this and in other areas, Dr. B is often grappling with the magnitude of psychoanalytic theory. One way that he orients himself is by maintaining certain personal tenets which support his faith in the psychoanalytic process. He describes them in this way:

> The faith is in this really simple idea—if somebody comes and talks that it will be helpful for them. That's it. Like at the most basic level for me. *Eventually* you can have faith that there'll be some kind of connection between you and that other person. It will be something you can hold and something you can work on.

Dr. B also holds a model in mind for the therapeutic interaction in which the analyst and the patient are both relating at an ideal level. He says:

> Some terrible things can happen in psychoanalysis by people who adhere too rigidly to either side of that dynamic. Just terrible things and I guess that is some of what gives psychoanalysis its power. Because to maintain that tension is a really great thing. Without being too stupid about this, it is a really beautiful thing if you can stay in that moment. Without becoming authoritarian and without becoming too narcissistically self-involved, you can just generate this long lasting moment… beautiful… you know? Beautiful and rare and where else are you going to get that? …two people actually meeting without one exploiting the other.

As Dr. B's clinical examples reveal, he grapples with his faith on a highly personal level. He provides a number of different examples in which his faith in the analytic process has been and continues to be tested. For instance,

at the time of the interview, Dr. B was in the midst of negotiating a therapeutic enactment. His discussion of this allows us to observe the subject as he questions, defies and works to make sense of an ambiguous situation. He said:

> So, I'm going through something right now with an analytic patient who's going on a three week vacation. And I have a policy about how I handle that in terms of a fee and made up appointments and stuff, but she's challenging it and I'm finding myself really resistant to her challenging it and I don't know why. I feel like look I've got a policy and why doesn't she just accept it? … And I know that, that's something. I know it's something because I'm not struggling with it. I'm not thinking about it. I'm not thinking 'huh that's interesting"… Why am I not open to negotiating this issue with her? No I'm thinking 'Why can't she just understand this is the agreement? What's the problem?' And I doubt it's the money because I've thought about it and it's not going really be that much. She wants to kind of go halfsies's on it and the money wouldn't make much of a difference really. I don't know what it is, but something really bugs me about it. And she knows it too. She's furious with me, but she doesn't know what it is. She knows that I'm not being a way that I can usually be. So I guess over time she's going help me understand what it is that's going on. I feel like that's the whole, that where the whole action of it works. Something's going on unconsciously in me and that's partially a product of she and I interacting. Having to do with the vacation, but also having to do with whatever we've been talking about. And she's going help me understand what the issue is and it's going to feed back into this relationship and what we've been talking about. It's completely cool. It's completely cool. It's like I'm a vessel for the relationship, but not an empty vessel like some kind of container bullshit, like this empty container. I'm there as a person having a feeling and she's going help me understand

> it so I can understand her feeling about it. Yes, it is really cool, but it's really fragile too because she can get really angry. It is tough. So, there's always that fear associated with it for me. That's she'll just, she'll think like 'well never mind' and just walk away from it and that's terrifying for me.

Dr. B provides another clinical example in which the patient's rage elicits doubt in the subject, but his analytic core remains in tact. Dr. B is able to tolerate the patient's affective maelstrom, and accrues a positive therapeutic experience which bolsters his faith. He reports:

> I've been seeing a woman for about three years and she's, she's very scared of her anger. She's very scared that if she gets angry it will kill her parents and that she should just buy them Christmas presents and smile and it's been really hard to coax her into a position to express the anger that she does have. It will show up in a dream or in something that she's… a short story that she's written… And she and I went through a very tumultuous period in the transference, counter-transference during the summer, this last summer where she just hated me. She would come to sessions very late. She would refuse to talk. She would start… she *really* started to hatefully talk about me and the process. I did my best Winnicottian thing with her and I survived and I didn't retaliate and I was consistent and I was there and I acknowledged some of what she was saying and she came through it and she came to the other side of it. As she said a couple of months after that experience things started to shift around inside for her, things felt different and it was remarkable to me. You know? It's a remarkable experience when somebody can have that experience.

*Interviewer*: Why this case as an example?

> You were asking about faith in the method and you know, there are plenty of people I see who get better. But the example of that woman seems to me more of an example of faith than of just going along doing work without any kind of disturbance in the work.

Dr. B maintains his faith in his work has been by managing his goals:

> One way that I've told myself for a number of years, 'what you should be doing, what a goal is' … and one thing that I'm more happy with is that when somebody comes to me and I really want them to get to know who they are. I think that's a really valuable goal and if they're less dissatisfied in their marriage and if they get a better job , well, those are nice things, but I really want them to get to know who they are a little more.

A clinical example of this is as follows:

> That would really be something, that my patient knows, that he would be thinking like 'I'm the guy who's so hurt, that I keep wanting like this big do-over' 'And that's who I am. That's the leitmotif of my existence. That's my theme. That's how I go into the world all the time.' That would be great if he could do that. I think he does it at times. You know, he'll see an underage girl and he's somebody who actually has been tempted in that area before and he's starting to say to himself *'Wait a minute, she doesn't know me. Why would she want to make me happy for the rest of her life and kind of slave-ishly look after my every need?'* Great! It's not exactly the insight that I would really want about who he is, but it's a great deal of reality testing.

A clinical example of Dr. B's revised goals are presented here:

> You should always be questioning and asking what is going on . And if the treatment is working and if it's doing any good. And is that change a

result of anything that happened here? All these questions should always, I think, go on, but in the other sense there are a lot of people for whom when you're working with them, it seems… I certainly wonder, they're not getting it. They just think too concretely or I met with somebody this morning who makes me think of this. He's somebody who lives psychically so much in a fantasy world, so much that doing the work with him is like making a design in the sand and the tide comes back in and just washes it away. But for years and years and years and we keep doing it. Oh, his life is improved tremendously, but he still lives in that place. He's still waiting for that kind of magical woman who's going to make him feel great about himself all the time and he behaves as if that's a reality and he looks for her…. Well, I've changed over times too. There have been times when I've been much more confrontative [sic] about that fantasy. There are times where I've let it alone to try and see if some of the work we're doing will affect it in not as direct a way. We've tried to do interpretive work. I've tried to do genetic work around it. There are certain transference implications of it that I've tried to tackle, but you know as regards to that issue of faith it is just there. And it just stays there. It makes me think about what the limits are of what I can give to him. You know, he comes from a very awful place of abuse, severe abuse and we've constructed a pretty good life for him. But he can't enjoy it and maybe that's the best he can do. At times the phrase has gone through my mind when I've sat with him, that he has more than he ever wanted and less than he dreamed of. And maybe that's going to be it. So maybe there's something about faith that involves not keeping hoping for something else… You know? Saying 'this is what we've got'.

Dr. B's feelings of impatience, hopelessness and resentment towards a patient are acknowledged but do not dampen the analyst's faith in the process. He says:

> There are patients with whom at times I've felt hopeless. I guess there are some people who I feel

hopeless about because they won't do a therapy like they won't do a process. Like I saw a guy last year who was in the middle of his mid-life crisis. He was just having an affair and he came to me because the affair was breaking up and he wouldn't leave his wife. He still wanted the affair and he'd show up sometimes, other times he wouldn't. He'd pay his bill a couple of months late. And I got a call from him about a week ago, saying 'I'd really like to come in and see you. I've got so much to talk about,' and I left him a message back saying I could see you at this time and he never phoned back. I feel pretty hopeless about him… I feel like if he could make it here, if he could make it to any analyst's office and he could talk then there's hope for him. Then something could be done, but he feels to me like one of those medical patients who's non-compliant with their medication. Like those are the hardest people of all, but if you can get somebody to the doctors regularly for their checkups and for the… then you got a chance of managing something. But he's somebody who's like got a heart condition and won't take his heart medicine.

Dr. B talks about some of the sources of his faith:

I think over the last years I've seen people get better. And they've gotten better and their lives are better, but, but that's not the source. That's something that's certainly reaffirmed it … I mean, it has to be something very personal. It has to be something very early, but I didn't see a psychologist when I was a little boy. And I didn't have much exposure to something like psychoanalysis. I don't know. I'm not sure what it might be… I don't know how it would relate to the idea of hope or faith or, but there's something, there's something attractive to me about being in a profession or in studying something so intensely that's of little interest to other people. The parallel that I think about often of is like an astronomer, a deep space astronomer. Because for me that stuff is so important but nobody cares about it. We found a new planet, well yeah fine. This has always seemed to me kind of like that. Like it's *so* important but nobody really cares about it and that's like, like a perfect fit for me, personally.

As Dr. B has become more comfortable in his work, he has felt a greater sense of freedom to use theory. "I think like a lot of people I adhered to the theory initially and then when I felt more comfortable to use the theory, rather than the theory using me, it opened me up to think about things." Over time he has also tried to be realistic about the patients with whom he can work. He tells about a woman who came to see him, but they "did not click". He referred her to another analyst and a match was made. For Dr. B, this type of situation does not diminish his faith, rather it sustains.

Dr. B relies on self-care to help him maintain his faith and ultimately his own psychological fortitude. He says:

> I struggle with it. One of the things that helps me is if a person can pay me. If they can pay me a fee that I feel like I'm not being kind of messed with. That helps, but there's nothing worse than having a really hopeless patient at an extremely reduced fee. Well, in the idea of like self-care for the therapist, I think that for me, I have to create an environment or an atmosphere where I feel that in order to help this other person I have to feel like I'm being taken care of. I can't feel like the mother who hasn't slept in three days and then say 'it's got to be really difficult for you to not have that happen,' because I'm going to snap and I'm going to feel taken advantage of and I'm going feel hopeless myself. So I have to have certain conditions with a really hopeless person in order to feel like something can happen.

**Discussion of Dr. B:**

In Dr. B we see an analyst who, from the outset, arms himself with a deeply philosophical and ideological commitment to psychoanalysis. His conceptualization of the psychoanalytic process appears to organize and anchor the subject. It is quite telling that Dr. B explains to the interviewer that in accepting the imperfections inherent in psychoanalysis, he is able to see its strengths. He notes "To consider faith to be a problematic concept. And as far as I'm concerned, the more that you are engaged in the problem, the more faith you have."

At the time of the interview, Dr. B was in the midst of a challenging interaction with a patient. The analyst was confronted with a number of unbearable situations that tested him, including managing the patient's anger, his own unformulated anger and the ambiguity if the situation. Ultimately, he feared that the patient could walk away from the treatment at any time. The analyst reflects on the forces working to lure him from the therapeutic stance. He said " I'm finding myself feeling resistant (to the patient's request)…and I know that's something. I know it's something because I am not struggling with it. I'm not thinking about it. I'm not thinking 'huh, that's

interesting'." Dr. B maintains enough distance to think about the process as it is occurring and becomes aware that he is acting concretely and personalizing the conflict. This optimal level of detachment allows the analyst to utilize the frame and keep alive the context of the interaction. We can see him working out the problem in his head— she is asking for something, he is angry, he is aware of his strong reaction, he sees the patient as helping him gain a deeper insight into his reaction which in turn will feed back into the relationship.

In the next case discussed by Dr. B we learn about the subjectively unbearable situation of the patient's rage and disappointments. To this, Dr. B endured by maintaining his therapeutic stance — "I did my best Winnicottian thing"- and uses it as part of the process. The patient's strong negative feelings activate the analyst's faith. The patient tells the analyst that "things started to shift around inside of her," which may indicate a deep structural change. Dr. B kept his therapeutic stance and the frame in tact, allowing for a productive phase of treatment to develop.

In yet another example, Dr. B discusses the lack of progress with a patient, but he does not personalize it. Instead of shifting <u>his</u> position from an analytic stance,

he considers the limitations of the patient or the treatment pairing. While Dr. B admits to trying different techniques, such as interpretation, confrontation and "benign neglect" of certain issues, he remains firmly rooted in his therapeutic stance. We see the subject make peace with the limitations imposed by reality in this way: "He comes from an awful place of abuse… at times the phrase goes through my mind when I've sat with him that he has more than he ever wanted and less than he dreamed of. And maybe that's going to be it…"

Dr. B continues to hold his view of the analyst in the case of the middle-aged man who won't come to session, as well. He sees the patient as "noncompliant," as if he is not taking prescribed medication for a heart condition. Dr. B admits to feeling hopeless in this case, but still relies on his belief system to help him hold his ground.

Dr. B's sources of faith in the analytic process range from early, diffuse personal experiences to the accumulation of successful treatments. For this subject there is something deeply meaningful about attending to aspects of human functioning that may be considered inconsequential by others. This value, this faith, is maintained through a deep appreciation of authentic human connection and the possibility of interacting with another

person in an egalitarian and collaborative way. The democracy of psychoanalysis is brought into focus in the therapeutic relationship.

Faith in the analytic process is also preserved through holding up the goal of understanding. Dr. B wants patients to know who they are. A useful byproduct of exploration is change—but that is not the primary goal. Finally, Dr. B acknowledges that self-care through charging an adequate fee is essential. He compares himself to a sleep-deprived mother when he feels depleted by his work. It is interesting, because Dr. B's seeming healthy narcissism may be what allows him to feel entitled to ask for compensation for his work. It is his job, his role as analyst, that allows him to endure otherwise unbearable situations.

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**Dr. A**

Dr. A is a 54 year-old psychoanalyst who was trained as an interpersonal psychoanalyst and has been a practicing analyst for ten years in New York City. Dr. A presents as an unfussy, thoughtful and innovative analyst. His spacious office is decorated with photographs of landscapes and many personal items. He spoke openly and enthusiastically about

his personal life, clinical experiences and views on the analytic community.

In general terms, Dr. A describes faith in an academic yet personal manner:

> We have this abstract idea which we call the psychoanalytic process. That's some sort of ideal way of conducting the process of change between two people. Those of us who strive to be analysts learn the process and do so imperfectly and we screw up. In some ways you can have this ideal which you strive to reach but fail to do, daily.

The analyst also talks about faith in the process as related to the patient's potential for change, thus fueling his belief in the treatment. He describes it here:

> But I think just the act of the person coming to treatment … for the most part people come to treatment cause they're at the end of their rope but if they were really at the end of their rope they wouldn't, they wouldn't be in our office. They're here because they have some faith, some belief that things can be different. Often it takes … an enormous amount of pain to get them there.

On a more personal level, Dr. A describes his faith in the psychoanalytic process and the way it keeps him engaged, even in the most emotionally challenging times:

> I think it's something that occurs to me both in my best and my worst days and moments-- in the sort of average day at work. I'm not so sure that it's in the foreground but in times of real stress, in times of real duress, in real problems or doubts either about my own inabilities or my patient's inability to change. I think with patients who have lost their faith. When patients are particularly despairing

> and/or then hostile and aggressive so that their despair comes out in ways that are personal. Since I work from an interpersonal perspective, it most generally comes out in very personally felt ways for me. So if a patient is despairing and angry and feeling like "it's a waste" and that they're being used and that they are being misunderstood or that the work is really for the analyst's benefit. It becomes a source of a lot of anger and hostility. Those are times when I feel it. The worst thing obviously is to be retributive. And faith in the process, that what is actually what's going on in those moments is part of changing. It's something that helps me stay in the chair. In general, in those sorts of interactions with people it is something I rely on.

Dr. A's faith was shaken in the wake of subjectively unbearable experiences in which he felt ineffective as an analyst or weakened personally. He began to doubt himself — but not the process. He says:

> It would be more accurate to say there are periods of crisis of faith. There have been periods of time in practice when patients have left treatment and I then wonder about myself. 'Am I somehow losing my edge? Is there something false about the process?' Let's say a number of patients will terminate either abruptly or over a period of time, even say due to extenuating circumstances like 'I lost my job or I'm moving,' there can be a challenge. That has an impact on other parts of life that are important-- like making a living and your own sense of where you stand in the hierarchy of the culture and how you're doing in terms of your standing with your colleagues and things like that. So there can be despairing. There have been despairing times. I'd say about two and a half three months when I took a big hit in hours and I started to have some crises of faith. Though I think to be perfectly honest that was more a sort of personal questioning of my *own* abilities. What was I doing or not doing?, as opposed to a crisis

> of faith in the process itself. My own personal knowledge about myself and how sometimes I can regress under, under challenge and pressure.

Part of Dr. A's psychoanalytic ideal includes a conception of the frame. He believes that the canon holds enactments as "failures" in which the analyst encroaches on the frame. He says, "Enactments, in some ways, the way they're written about are failures. They're trespassers so that there's frame… But the literature of enactment now celebrates the mistake as a kind of triumph to the degree that it's understood and worked through between the participants. So, the failure becomes the thing that gets re-metabolized, re-digested into the process and becomes the process."

This concept of enactments and having a "particular frame in a particular treatment" provides the backdrop for one of Dr. A's clinical examples in which faith in the psychoanalytic process sustained him through an unorthodox treatment. The analyst provides this example to highlight the robustness of his faith. He recounts the following case:

> I think of a case in which the frame was set up originally that the patient would be in treatment twice a week. For the first two and a half years she never was and so that she would come to one of the two sessions and without exception not to the second. So whichever one it was that she decided it would be that week she always kept me guessing

> as to which she would come to. She always called in the session that she as not going to come to during the session time. It became clear to me very early on that this was something that she needed to do. If she needed to not come there needed to be a scheduled session for her not to come to. She needed to know that I was here waiting for her while she was wherever it was that she was. This is where I think the faith part of it comes in—it was very clear to me that with this particular person that this was not to be interpreted. It was to be <u>lived through</u>. When she was ready either to talk about her not coming or to come, she would. But that a big part about what was going on in treatment was the living through of this consistent absenting of herself in a way or in some ways being present by not being present. I think without a kind of faith in the process or at least in this particular process, in this particular way this process was working out, this treatment would have foundered. That my hunch was that interpreting this would destroy the treatment… It's not an experiment we can run obviously.

He continues:

> I think the more consistent it became, the more my sense that I was doing was supported. In the end, we did talk about this, but only after she began coming to treatment twice a week, had done so for a while and we began talking about termination. It was in the termination phase of the treatment that we began to be able to talk about what had happened at the beginning of the treatment. She was able to say quite clearly that she needed to know that I was going be there. She needed to establish a safe enough space for herself, her way, and that that had been a critically important thing to her. In sort of from thinking about it from your perspective—in establishing her faith or trust.

In another clinical example, Dr. A recounts a decision that challenged his faith in his work and stirred up uncertainty. Dr. A describes this episode in which he

had to endure a patient's intense rage and his own self-doubts:

> There was a situation in which I intervened in an aspect of a patient's life that took place outside the room. I did so under duress because it was a situation which was imminent. I didn't have a lot of time to consult with colleagues. Either I was going to intervene or I wasn't. It was within a period of twelve hours and I made a judgment call. The best thing to do was to intervene. Again, it was an unusual situation because it was an analytic patient and it involved something outside these four walls and it was a difficult decision. It was a complicated and difficult choice. Whatever I did, that is to not intervene would have been to do something. So whatever I did would impact my patient. He may or may not have known about it, but I think he probably *would have* eventually because it involved other people that I knew well. So I tried to make the choice based on what I thought was in my patient's best interest. There would have been no way I saw at that time to collaborate with my patient about it without disclosing a bunch of stuff that would have impacted him as well. This is very uncomfortable position to be in as we're often protected here from what actually goes on or at least we think we are. So the first consideration was what do I think is going to be best for my patient? I could make that choice, but I wasn't too clear about what would be best. So the second consideration was: how will I most feel like me? If things go badly, how will I best be able to respond to the patient if he's unhappy with what I've done? The path that I chose was a path which fortunately I thought would be best for my patient, although that without the patient's input is a bit arrogant. It was also the way of going about this that felt to me like I would be most able to feel like me. It turned out that my patient was extremely angry and very, very unhappy with what I'd done. I felt terrible about it, absolutely terrible. It threatened to end what was till then a very engaged, if at times, very rocky treatment. There was a period of a couple of

months in which I had some real crises of faith, again about in this particular case, my choice.

Dr. A goes on to say:

> So what if this were just a mistake? Maybe I just screwed up. Either way it's certainly something that my patient and I have spent a lot of time speaking with each other about. It happened a couple of years ago. We still have not completed the process about it. The patient still feels I betrayed him. For my part I completely, well, I don't know how completely, but I do understand his experience of it and yet, I'm not yet convinced that what he ascribes to me, by virtue of my action, is something that resonates with me. So we still struggle. In other words, this one wouldn't get written up yet … I think it's more a question of faith in myself. This patient is a particularly sophisticated man who's *own* faith I think in the process is very solid. I don't think that our faith in the process was threatened as much as the faith in **our** process … I've certainly talked about my misgivings about my choice and invited him to as well, though he hasn't needed much encouragement to air his views about it. I have talked to him about my doubts about it and aside from the initial sort of trauma that I think I felt when he reacted *as* intensely as he did, we have gotten to talk about it and he's been curious about it and open about his wanting to know what was going on in my head and how I could have thought what I thought and so I shared with him pretty much in the language that I did with you this issue about a, significant aspect of the choice having to do with what would have felt more authentic. If given either choice, in other words, if I didn't intervene and he had found out about it and was as angry as he is that would have been one perspective, one situation. The other perspective …the other situation would have been if I did intervene and he was as angry as he is. Which of those cases would I feel more authentic, would I feel more solid? In other words how could I sit in the chair, how could I hold myself as a caring analyst in the face of my patient's feeling quite the opposite? His feeling hurt and abandoned? This was a big part of what

made me choose what I did, so I could feel like I did this as me. I didn't do it based on some theoretical or technical-theoretical rule. I did it based on what I *felt* about myself, and what I felt about him, and what I felt about us. So to me it wasn't a question of having lost faith in the process but rather how am I going to interface, interact in the process so I can continue to feel like *me* in it. And for *me*, that was, to be active in this way.

Dr. A explains the ways that he managed his faith and doubts in both clinical examples. He feels that had he taken the first case to a supervision it would have been challenged. He says:

> I felt that the standard sort of technical canon would require that this *acting out*, if you will, be interpreted. I have a different perspective obviously and did then… In some ways I felt that it would be challenged from the outside. As I said before, that I needed to live through this with this particular person. Part of my sense about what makes treatment's go is a lot about what's done together not just what's said to one another so there was something I think, powerfully communicative um about her not coming and about my not speaking to her about it. What I did with it, what I did about it was different than I think what she expected. I mean another part of this was …which we talked about later on was a… her sort of seduction into a punishment, that her expectation was to be punished for trespassing.

Dr. A continues:

> In the first one, I never took that to a supervision group. I was in it and it felt to me like there was nothing to talk about with anybody else. I didn't <u>*not*</u> bring it defensively. It was like there was nothing to bring. This was the process. In this second instance there was a gap between my sense of participating in the process and the process. This

made me feel like I better bring this to some other people who know about the process.

Like many of the subjects interviewed, Dr. A's identification with aspects of his patients has acted as a way to fortify his faith in the analytic process. For Dr. A, this was most apparent earlier in his career. He said:

> I felt most hopeful with people who I felt were suffering from some of the things that I'd suffered from. Since I knew that it had worked for me, I felt how could it not work for them? It was obviously a naïve view and one that doesn't always play out the way one hopes. Nonetheless it was something that sustained me earlier on when I was a lot more anxious about my role as a therapist. So my own kind of experience, my own sort of transformation through the process was something that sustained me…

Dr. A derives faith by homing in on the patient's potential and ultimately faith in the process. He says:

> I think that at least originally the first blush in my affection or lack of it for certain patients, I think that's a sign to me that um I have hope… for the kinds of change that's possible so I start to pay a lot of attention to that and try to do a good deal of self-analysis in terms of my attachment or lack there of. My looking forward to seeing a certain patient and my dread about seeing another which says a lot to me about what I'm seeing as possible, for the patient on the other end of treatment. It's different for each patient and then it changes within the context of each treatment.

Dr. A sustains faith is by adjusting his expectations. He reports " So part of the trick I guess, if you want to think of it in terms of hope, is that you are trading what

you're hoping for so you can sustain your work. If I am hoping that this guy [who is severely depressed and socially withdrawn] is going to be giving parties every week, it is going to be hard to continue the treatment. If I hope maybe he can get out of his house once a week without coming here, you know maybe that's something…"

**Discussion of Dr. A:**

With the case of Dr. A, we meet an analyst whose faith in the analytic process has been a constant force that comes into focus in times of real need: when he is faced with the limitations of his patient's potential and when he is confronted by his own inabilities or doubts. Dr. A considers himself to have solid faith in his work. Since Dr. A works from an Interpersonal perspective and his interactions with patients are "very personally felt," his sense of faith is dependent upon his view of his effectiveness.

I'd like to suggest that Dr. A's faith in the analytic process might be less consistent than he believes. In a close analysis of clinical material, we see that Dr. A's crises of faith are crises of self. Since he uses himself as the most prominent instrument in his work (rather than

the therapeutic stance or frame) the analytic encounter becomes the source of doubt. In the first case discussed, Dr. A talks about a female patient who consistently missed one of her two scheduled sessions each week. This pattern occurred for years and the analyst did not interpret this behavior until the termination phase. From Dr. A's perspective, it was his faith in himself and his intuition that aided in maintaining a type of therapeutic cohesion. As he said, "It was very clear to me that with this particular person that this was not to be interpreted. It was to be lived through… My hunch was that interpreting this would destroy the treatment." One wonders *what* would have destroyed the treatment? The patient's rage or fear? The analyst's inability to tolerate such threatening affect? Had he not enough faith in the analytic process to believe that her awareness of this may have benefited her? In this situation, it appears that faith is anchored in action, rather that analytic interpretation.

Dr. A explains that he did not bring the case to supervision for fear of it being challenged by colleagues. Later in the interview though, Dr. A provided a different reason for not processing the decision with colleagues—he felt there was nothing to talk about. He continued, "I didn't <u>not</u> bring it defensively. It was like there was

nothing to bring. This was the process." These two responses indicate that an internal discord exists, which in turn may point to an ambivalent faith.

The second clinical example that Dr. A shares is one in which he intervened in an analysand's life outside the consultation room. The analyst reports that he did not have enough time to discuss the matter with the patient, and therefore had to rely on his own understanding of the patient and of himself. As he recalled, "The first consideration was what do I think is going to be best for my patient? So the second consideration was 'how will I feel most like me?' … It turned out that my patient was extremely angry and very, very unhappy with what I'd done. I felt terrible about it, absolutely terrible. It threatened to end what was till then a very engaged, if at times, very rocky treatment. There was a period of a couple of months in which I had some real crises of faith, again about in this particular case, my choice."

This analyst's choice to intervene in this case can be seen from different perspectives. To initiate an action outside the treatment room could be seen as his "inner act of freedom" (Symington, 1983)—a movement to act according to his unconscious. Dr. A emphasizes that he felt himself

to be in a bind, so the choice he made felt most productive for the patient and most faithful to himself.

From a different angle, we could also interpret Dr. A's responses to the situation as a crisis of faith. Unable to trust his own ability to withstand a subjectively unbearable experience, he loosens the frame. In so doing, he falls back on the view of himself as "caring," rather than rigid or abstinent. As he said:

> How could I sit in the chair, how could I hold myself as a caring analyst in the face of my patient's feeling quite the opposite? His feeling hurt and abandoned? This was a big part of what made me choose what I did, so I could feel like I did this as me. I didn't do it based on some theoretical or technical-theoretical rule. I did it based on what I *felt* about myself, and what I felt about him, and what I felt about us. So to me it wasn't a question of having lost faith in the process but rather how am I going to interface, interact in the process so I can continue to feel like *me* in it. And for *me*, that was, to be active in this way.

What we can see is that the analyst's actions are based equally on the patient's welfare and the analyst's view of himself.

In the first clinical example, Dr. A simply views it as "this was the process"—as if he and the process were seamlessly matched, thus giving him the confidence to continue with his technique. The second case he felt was worthy of outside supervision, though. In contrast, "In

this second instance there was a gap between my sense of participating in the process and the process. This made me feel like I better bring this to some other people who know about the process." I'd like to suggest that "this gap" is related to the patient's enraged response and the analyst's difficulty bearing such intense affect. Had the patient responded with relief or gratitude in the wake of the analyst's transgression of the frame, then Dr. A might see that this too "was the process". This is a clear example of the relationship between the impact of subjectively unbearable situations, the analyst's faith and the impact on clinical choices. Dr. A's apprehension makes him work both inside and outside the frame.

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**Dr. S**

Dr. S is a 56 year-old female psychoanalyst who has had an intense interest in psychology and psychoanalytic theory since she was in high school. She identifies her theoretical orientation as a cross between contemporary intersubjective theory and object relations theory. She has had an analytically–oriented practice for 17 years, and a therapy practice for 10 years before. Dr. S presented herself in a professional and formal way.

Dr. S speaks with tremendous passion about her faith in psychoanalysis. While she reports to have strong beliefs in the work, she considered leaving the field rather recently. She depicts her beliefs this way:

> My faith in psychoanalysis--- I don't know if it's faith or determination. I fight for a person. Once someone comes to my office, I probably am a great person to work with and also a lot of trouble because I will kill myself to get your life to work. This is my mother who has this kind of determination, but I am just so determined to help someone once they walk in the door. I take it very seriously. I've thought that psychoanalysis is difficult. It is very draining and very confining. That I have done. Last year in fact I thought 'you know, I'm done. I don't want to be a psychoanalyst anymore'. I have thought 'It takes too much out of you!' Also, I like to travel and move around. Your commitments to your patients in private practice are more than your commitment to your children because your children will grow up and leave home and your patients, not the same patients obviously they cycle through, but you will always have a practice that ties you down. It ties you down a lot and it drains you a lot. It can be very tiring work, emotionally tiring.

Dr. S provides a powerful clinical example in which she struggled dramatically with her faith in the process. Here is how she attempts to sort out the challenges with this treatment:

> Recently the treatment that I have going right now, that I'm the most concerned about—it wasn't the process that I thought was the problem, it was the relationship itself. It's what she [the patient] brought up in me. A great question that I think every psychoanalyst struggles with is if somebody touches on an area in your life that you have not

> yet resolved can you work with that person? And I felt this individual did that for me. I did what I think everyone should do, I got myself supervision and I'm actually working with a very high level person in another country. So we actually did this by telephone internationally because she's the best in the world. And it helped, she helped me… she helped hold the treatment until I was able to sort it out.

Dr. S describes the first years of treatment in which the patient was in a thrice-weekly analysis and would not speak. She says:

> Do you have any idea what that's like? And not only was she not saying a word, but she was clearly in so much distress. She was so dissociated, so disconnected from her distress, it was all in me. I suffered her internal life. … I would have killed myself to help this woman. So it's interesting how she just was all in me. I was feeling all her distress, all her anxiety, all her misery and wanting to fix it. …The first couple of years when she was being silent, there was so much going on non-verbally that it was never about doubting the process, it was about how to deal with this mess. Even though she was not talking she was doing everything non-verbally and so I was getting so much non-verbally from her and I could see she was in a lot of trouble. … She would occasionally say a few words and it wasn't that she was not try. She was trying as hard as she could and I knew that. Maybe that's why it didn't really enter my mind to have it not work or to lose faith in the process. Because here is this desperate individual in my office three days a week trying as hard as she could to do something. No, it didn't make me lose faith, it more incited me to stretch and do everything I needed to do to meet her need. That is why I ended up in this wonderful telephonic international supervision… it's such a joy to do that.

She continues:

> Honestly, most of my treatments go very well. It is going look prettier in some cases than others but you get that sense that it is moving along. With this individual it was not moving along. It felt stalemated and subjectively I was particularly distressed when I was with this individual. I felt much more personal discomfort than I do by far in any other treatment. … I was really doubting my own personal efficacy. I was also doubting something else, the fit between us. I'm relieved. I'm relieved. I'm relieved. I'm surprised by the changes in me. I didn't think those could happen. I was the one I didn't think could change, I knew she could, but I'm surprised I was able to grow in the way I needed to, to sort out things.

Dr. S uses a theoretical conceptualization to explain the intense doubt she was experiencing:

> What happens in analysis is the patient comes in to treatment and through projective identification, makes the therapist sick. Then the therapist heals the patient inside herself or himself and then can help the patient. This is what happened. She made me sick. This is what my consulting person was saying to me. You have to realize that this is coming from her but I had to heal it in me. Before I could heal it in me *I had to heal me*—like I healed her mother in me or something like that. It was really very challenging… She had found some way of crawling inside me.

Furthermore, the analyst doubted her own abilities to provide the necessary care for this patient:

> I thought I was wasting the patient's hope and that I was not delivering on what she was coming here for…that I was failing her. I worried about the ethics of it that I'm taking her money, I'm asking for her trust and I'm not delivering. That was my concern and I was quite anxious about that for months. That's what drove me to do everything that I needed to do to fix it, because I can't abide that.

The subjectively unbearable situation of the patient's rage was overwhelming for the analyst. She says:

> [The patient] was so unaware of her own deep aggression and destructiveness. … She was completely unaware of this, punishing me day and night to the point where she wanted to go have a consultation with another therapist about my treatment. I wanted to kill her because she wasn't aware of this, but her motivation was to get me in trouble. She wasn't doing the thing you have to do before you do that, which is talking to me about it. She wasn't talking to me about it. […]Now, it was an enactment of something in her childhood[…] there was all this terrible stuff and she was just replaying it […]

The analyst had reached a point where her faith in the process with this patient became deeply compromised. She admits:

> I really wanted her to leave and I couldn't get her out… And I said to her, 'you know you've been saying for months now that I'm hurting you and this isn't helping and I think we should talk about that. I think if you really feel that way about me and I'm not the right therapist for you … We've done a lot of good work together, we've already changed blah, blah, blah, blah, blah in your life. This would not be a bad point for you to stop working with me and work with someone else,' and I said that again, hoping she would leave. She didn't leave. … Now in retrospect I see where she was going and what it was it about. She still doesn't fully see that and I don't know if she has to, but we have a very different relationship now and it was crucial for her to go through that… At the time I started working with her I really was not experienced enough to deal with all she brought to the table… I didn't know enough and in a way I

didn't know enough to help this woman but we both hung in with each other and in the end it really worked beautifully. Her life is wonderful now.

Interviewer: Why do you think you both hung in?

She did. I didn't. I didn't, but she did. I give her the credit for this one. Now, I didn't act out against her in any way, so I adhered to professional ethics. That's all I can claim on my part. … I honored the spirit of the profession, that if she wanted to stay that I would. Was it masochistic? Maybe, I don't know. Should I have thrown her out? No I don't think so… The amount of change this work has facilitated in her life is phenomenal and she has a great life now and she's really happy with her life. But that's her, that's her. I give her a lot of credit and it's really nice for me because having once hated her, I really like her now and I have so much respect for her. I just admire how she's worked with this treatment.

Supervision for the case enabled Dr. S to detach and engage the treatment in a more productive way. She was able to use the supervision to gain a perspective that was unfeasible in the face of the patient's rage and misery, especially as it intersected with her own issues. At another time when the patient threatened to leave, the supervisor told the analyst "well, she may leave but you'll still just do analysis." Dr S's confidence was shored up: "You know, it was just a great answer. It really relieved me of the need to keep her in treatment. She's still in treatment, so I think she helped me."

In another clinical example, Dr. S questions the analytic method for a particular patient. She says that

due to the severity of the patient's depression, a "modified therapy" might be better. She says:

> I have a very disturbed young man that I'm working with and the treatment's going very well. He loves coming and he feels I'm saving his life. But I get worried that analysis is not an adequate treatment method for him. I'm doing a little research on DBT and I'm trying to incorporate other… it's a very modified… well, it's not an analysis, it's a therapy. It is because of his actual need. He is so on the edge. I mean he was seriously suicidal when I met him. Now he's not at all. He has a whole life… he's in his 30's and he's got a whole life that he hasn't started yet so he has a whole lot of work to do, this kid. So sometimes I just think that analysis doesn't work for every single person.

For Dr. S's sources of faith in the analytic process are rooted in her religious beliefs and her appreciation of analytic theory. She says:

> I really think my religious faith has a lot to do with it because I just think God tries to help people all the time and I see somehow psychoanalysis tapping into love in a way helps people… You know people help people. It is partly religious faith and I would also say the turn to relationality where Fairbairn's favorite statement, you know, 'libido is object seeking.' And then everything that has flowed from that also gives me faith because then that tells you if you're in a relationship. That's what people are looking for. That's the crucible in which we become human. Attachment theory of course adds to this, so that's a second important source of faith. So that theoretical tradition, that scientific model as it were, that it is a relationship that creates the human person. It is within a relationship we become who we are and so it's within a relationship that we become healed.

Additionally, colleagues and mentors have been sources of faith for Dr. S. In particular, Dr. S stated that she is deeply inspired by the humanity of her colleagues:

> I mean they're all productive career psychoanalysts first of all. I mean these are three people that have written prodigiously and have been very influential in shaping the field, but they're also three really good human beings—generous, kind-hearted, loving, able to tolerate much in life without getting defensive. They're good-hearted people and that means a lot to me. And they have good full lives.

According to Dr. S, her first analysis with a famous analyst did not nurture her faith, but she is experiencing an enriched her belief in her work due to her current therapy. She recalls her first analysis:

> It wasn't that he was in absolute terms a bad therapist, but considering who he was in the field, you would have thought he would have been a better therapist than he was… I'm a complicated case because I went on to work and I'm still working with her [a new therapist], it's been a long time now, once a week with this woman. I believe in my work much more through the work I did with her. She got me even after I'd done the whole nine years with this other guy, so you never can forget that and I don't forget that. She and I, from time to time, mention that because I criticize him a lot, but we both remember that I have the luxury of being able to criticize him partly because of the good work he did with me … But the work she does with me I think is elegant … I actually agree more with her theoretical orientation than I did him. She's Kleinian and he was not, so that may be a piece of it. I would say unequivocally my experience with her is in fact deepening my belief in my own work and in the work.

At this point in her career, Dr. S feels that she has integrated theory and experience into her life and this sustains her faith. She describes it:

> I think it takes a certain level of experience where you've integrated theory with practice and you've applied it not only to your patients, but in your own life and it causes you to trust the concept more cause you've tried. … You've experimented with them in the laboratory of your work and the laboratory of your personal life and they've worked, so that's the ultimate test.

For Dr. S, faith in psychoanalysis has been essential for her work. She says:

> I'm trying to imagine how you could practice if you did not have faith in it. I think you go through phases in what that phrase means, faith in the psychoanalytic process. I think when you're a student and you're younger, the psychoanalytic process is something that people before you have developed, historical figures have conceptualized. It's now deposited in texts and you study it but when you're more experienced you been to realize that no, you're shaping the psychoanalytic process. You're the one saying what it is. You're forming it all the time so it really becomes an extension of what you yourself are creating and that I have a lot of faith in because I have taken the trouble to train extensively. … I don't see the process itself as having an independent existence much. The process is really just me and another person.

**Discussion of Dr. S**

The equal intensity of faith and doubt in the case of Dr. S is what makes this vignette notable. Dr. S's resolve to help patients is emphasized throughout the interview.

She speaks of her dedication and wish to fix the lives of the other. But, we also hear echoes of the analyst's frustrations and fears. Though she loves the profession, she wrestles with the doubts and dangers intrinsic to psychoanalytic work.

Dr. S feels that extensive training and work experience have helped her in shaping the analytic process: "You're forming it all the time so it really becomes an extension of what you yourself are creating and that I have a lot of faith in because I have taken the trouble to train extensively." Like Dr. A, who also identifies himself as a creator of the process, this subject puts herself at risk to the dangers inherent in this work. Dr. S wants to be of service and engage on a very personal level with the patient. In so doing, she gives up a distance that is optimal for maintaining use of analytic tools.

Dr. S recounts a case of a middle-aged woman who suffered psychological traumas at the hands of an intrusive and controlling mother. The patient barely spoke for the first two years of her analysis and when she did communicate it was rife with aggression and hopelessness. Dr. A became overwhelmed with the experience of working with this patient and was catapulted into a crisis of faith.

Dr. S had lost faith in herself, her patient and the relationship. As the analyst reflected on the experience:

> It felt personal. It is what she brought up in me. A great question that I think every psychoanalyst struggles with is if somebody touches on an area in your life that you have not yet resolved can you work with that person? It felt stalemated and subjectively I was particularly distressed when I was with this individual. I felt much more personal discomfort than I do by far in any other treatment.

It appears that the overwhelming experience activated the analyst's doubt, which in turn weakened her ability to hold her work metaphorically. In her fear, Dr. S's cognitive and affective capacities collapsed and she was unable to tolerate the patient's action and feelings, which were transferential in nature. Only through the fortification of supervision was the analyst able to regain her faith.

The analyst's doubt became manifest in various ways. She had thoughts that the patient hated her. The analysis was too expensive. The work was moving too slowly. She was not performing her job adequately. She said:

> I thought I was wasting the patient's hope and that I was not delivering on what she was coming here for. I was failing her. I worried about the ethics of it that I'm taking her money, I'm asking for her trust and I'm not delivering. That was my concern and I was quite anxious about that for months. That's what drove me to do everything that I needed to do to fix it, because I can't abide that.

Here we see that the analyst did not feel effective or ethical. Like other subjects of this study, she linked this feeling to her lack of faith in the process.

Dr. S, with the aid of her supervisor, used theory to create a feeling of order for her experience. She noted that projective identification made the interaction with the patient alive in her. She talked of a psychic merger in which her own mind became poisoned by the patient's.

Dr. S's crises of faith had significant technical implications. She said that she tried to terminate with patient, but to no avail. The patient refused to leave treatment. Over the course of time, the therapeutic dyad began to find its stride. It is unclear if this episode in the analyst's career will act as a future source of faith in other situations.

Dr. S's decision to hire an outside supervisor was essential. The subjectively unbearable situations that Dr. S had to face in this case made it impossible for her to do her job. Through self-exploration and professional support, Dr. S regained her beliefs and her ability to contain the patient's experience. She said that her supervisor "helped hold the treatment until I was able to sort it out." As Dr. S talked about regaining confidence in the treatment,

she noted that the patient worked hard and had made improvements. But she also noted that her own evolution played a part in this, and conversely it played a part in her evolution: “I was the one I didn’t think could change, I knew she could, but I’m surprised I was able to grow in the way I needed to, to sort out things.”

The crisis of faith that Dr. S endured had personal implications as well. She says, “Last year in fact I thought --you know, I’m done. I don’t want to be a psychoanalyst anymore.’ I have thought ‘It takes too much out of you!’ … It ties you down a lot and it drains you a lot. It can be very tiring work, emotionally tiring.” For the time being, however, she remains in her practice, but still thinks about an early retirement.

This case raises a question of the impact of the analyst’s analysis. Had Dr. S had a more satisfying and productive treatment, would her faith have been more sound? Maybe she never internalized her analyst, and thus had no real place of internal security. Additionally, this case taps into issues that remain unresolved for the subject. Dr. S acknowledges that her patient’s issues affected her own psychology. To her credit, Dr. S has been working through this with the help of the supervisor.

In this case of Dr. S, we can piece together some of the forces that influence one's faith. Here a seasoned analyst is confronted by a subjectively unbearable situation in which the patient is quite ill and the analyst is caught off guard. This, combined with the analyst's own unresolved issues, makes for a breakdown of faith. The analyst was unable to hold a therapeutic stance. She was blind to the metaphor of the transference and the symbolism of the enactment. It all became too real. But the analyst maintained enough distance to recognize that she had lost her perspective and hired an outside supervisor to provide reinforcement.

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**Dr. J**

Dr. J is a sixty-two year old psychoanalyst with a background in clinical psychology and other social sciences. She agreed to be interviewed in her Manhattan office located on the Upper West Side. Dr. J spoke in a soft tone with an honesty that was at times disarming. She has been practicing as an analyst for 29 years. In addition to her work as an analyst, Dr. J supervises for a

psychoanalytic institute and teaches at two different universities in New York.

From the outset of the interview, Dr. J states that she questions the psychoanalytic process on a regular basis and feels that this is closely tied to her personal struggles with self-esteem. Dr. J's relies on analytic methods and utilizes the power of the unconscious to raise awareness and promote healing despite her skepticism. She reflects on her expectations of psychoanalysis: "I don't think I had tremendously high aspirations for it , even in the beginning. Since it is a human process it would be flawed. I don't feel disillusioned about psychoanalysis. I think more disillusioned about the world—its possibilities. Not disillusioned so much as aware of the limitations." Dr. J thinks that the rules of psychoanalysis are arbitrary. Perhaps in a response, Dr. J uses various methods such as art therapy and hypnosis.

Dr. J. clearly ambivalent about the efficacy of psychoanalysis, says:

> I have worked with people for years and although I think they benefited from the treatment, it didn't really get what we had hoped it would. For example — a foot fetishist who wanted desperately to be able to love in a less rigid and controlled and perverse way and was ultimately unable to sustain a relationship, at least during the time that we were working together ... I feel sad. Sad for him, sad for me, sad for the process that it can't do magic.

> That sometimes people have so much damage that they can't really transcend it and get to more related, more connected place … And I do think he gained something from the treatment, although not as much as he would have liked.

Dr. J reports that the faith she does have in the psychoanalytic process stems from the encouragement she feels working with patients. She says, "I think the patients themselves provide a kind of inspiration, in that they've gotten where they've gotten. In having done so much work with childhood trauma people, it always amazes me that they've survived, that they've lived to this point, and however they did it —they did it." Dr. J also maintains a type of balance of hope by holding realistic expectations for her patients. She continues:

> A lot of symptoms that people might find horrifying, like self cutting, or eating disorders, or whatever, are less—even though I feel shaken by them, the overall feeling that I have is that it's amazing that people have been able to live as long as they've lived. So looking at people as having that kind of will to live, and seeing it in them, and seeing their ability to handle some horrendous things is very inspiring, and I guess I bring that perspective to every case. To be looking at it as a kind of miracle that somebody's been able to do what they've done. In other words, I'm coming from a different set of expectations about normality. My notion of normal is closer to minus three. Somebody else might be shocked and horrified that someone has this abnormal history. Another way of looking at it is, I think of PTSD as just a condition of living where the veil has been taken off and someone sees what life is really like. Whereas another therapist might use the symptom checklist and diagnose someone freely from the

> standpoint that someone shouldn't be having these symptoms.

Dr. J believes that her ability to locate the patient's potential is an important ingredient in her work. She expresses it this way:

> It is a starting point. People come for help with something, and in formulating what our joint goals are, it has to come from what we both think is possible and what we both long for. Often enough a patient isn't even aware of what they could hope for. With traumatized people, they're so beaten down and so, kind of, diminished that they've lost the capacity for imagining hope. It's often up to me to bring it in and to ask about the range of possibilities they may not have considered.…It's easy to get into a counter transference diminished state of my own and lose track of them [hopes], but especially in the beginning of the treatment it's easy to envision what this person might want and need.

Despite her questions about the analytic method , Dr. J carries on in her work by receiving support from colleagues. She reflects on her supportive relationships:

> I guess I try to sustain myself through a lot of conversations with colleagues like, doing a tremendous amount of processing about clients at night on the telephone with people, and they do the same with me, so we have a form of peer network… So we inform and inspire each other by seeing the meaning in each others' work. So that helps. And I guess I look for a lot of reflected appraisal to know I'm on the right track, and I get it.

In addition to contact with colleagues, Dr. J's teaching is a vital source of sustenance. She notes that:

> The teaching is another because that lets me step away from what I'm doing and look at it

> differently, and forces me to formulate ways of looking at people, that I can communicate about, and talk about what works and what doesn't, and also keep looking at the field differently.

Dr. J has had several previous analyses that have left her feeling frustrated and depleted. Her most recent analysis has begun to deepen her belief in the psychoanalytic process. Dr. J describes her current analyst as very active in the field "and is much more of a believer in psychoanalysis than I am." She continues, "I think moments with my most recent analyst are most present with me to help me steady myself and strengthen myself and help me think there is something to be done here. I can't think of a single event or marker… other than that. More of mine are little moments of my feeling despairing and her meeting that with something challenging. "

The subject's previous analyses were fraught. She candidly discusses her experience:

> The first one was when I was in graduate school, and it was helpful in that it helped me overcome a lot of my own most acute symptoms and troubles. That analyst then became much more Freudian, and that I experienced as a kind of betrayal… And I kept saying to her, 'You've changed, you're different, what's going on here?' She started out being very responsive, even making wisecracks, being very present, and very much herself as a person present in the room. I think that was extremely helpful. That treatment was very hard to end because I was really in the transference of a

> depleted narcissist, and very much focused on her as the center of my life, which was what was induced by her pulling back and withholding. And it was hell to break off the treatment with all of that unresolved. So the next analysis I had was the training analysis from X Institute. That was with a very crusty, individualistic, but ultimately very narcissistic man who was extremely not helpful to me. My years of being thirty-four to thirty-eight and forgetting to have children, and arriving at age thirty-nine and thinking, 'Oh my God, what am I going to do with my life now? Here's this thing that I always assumed would happen, and it hasn't happened.' Plus I had very serious fibroids which had been growing all this time, and I just ignored. So I hold it against him that he didn't listen to me about this, and wasn't helpful in helping me live my life. And then the next treatment was when I was a young mother — well an old mother. I had a child at age forty-one after having been told to have a hysterectomy by ten different gynecologists. And she had a child just the same age as mine, which is how we initially met. I worked with her a number of years in supervision before asking her to be my analyst because I wanted to check her out, and that was actually a good idea because it gave us a different framework for being with each other. And I think I took, and have consciously used much more from that treatment than either of the previous ones.

Dr. J believes that her doubts about psychoanalysis are intrinsically connected to her own negative self perceptions. She shares her thoughts:

> I think for me in my practice faith is formulated in much more personal terms like: "Am I the right person for them? Am I in some way letting them down?" It's not usually, or anytime that I can think of, framed as a philosophical question. It's much more, "What's the matter with you that I'm not getting better?" Or, "What's the matter with me?" which is being fended off by that question.

The ambiguity of analytic work is difficult for Dr. J. She feels a sense of relief when there is momentary order:

> I guess when it seems clear what someone is doing to get in their own way. Like in the treatment of a perfectionistic woman who's afraid of intrusion and reacts defensively. I felt a kind of surge of hope at the point where I realized this. I was able to clarify it for her and lay it out for her, and I felt like, 'Thank God, now we have a treatment plan.' It gave me a kind of mandate – a place to stand to respond to her in a much more active way than I had been. I had been much more swamped by her rationalizations, and not seeing this as clearly, and once this became clear… in other words, I was able to formulate a therapeutic position and that was—that gives me hope.

Dr. J describes periods in which she has felt stifled by her lack of faith. She says:

> I think [doubt] dampens down my own creativity because you have to believe in yourself in order to feel comfortable and fully alive and really present […] I've always had doubt. It used to be much more framed in terms of socio-political concerns like "Is it really the right thing to do to charge patients for sessions?"... I think I was also afraid of the whole encounter with – you know – asking people for X dollars a session. I both didn't approve of it, and was afraid to take that kind of a stand for myself ... I am beset by doubts – I mean, like individual doubts like, am I on the right track with this person? And kind of general doubts like, is this really what one should be doing with a life. Isn't' it a luxury? Isn't it elitist?

In the clinical example Dr J presents, we see parallel conflicts with some difficult issues that

have been central in the analyst's life. Dr. J

begins:

> It's not just me, but many of my colleagues are working with women who want to get married and have a family, and are working against the time clock. It's the cultural event of the century. I think that women patients who are in treatment in their 30's are prone to having moments of frantic "Let's get on with it here, I really want you to be doing more with whatever's the matter with me that I'm not getting married." I'm thinking now about a particular woman who — I guess she's been in treatment once a week except when she travels for business which is often. She makes a lot of money, spends a lot of money on expensive travel and dresses, and isn't saving money ... She is very choosy, even perfectionistic in the friends and especially in the men she dates. What's emerged as an issue now over the years (we've been working together now four years, since she was 32) is that her fear of intimacy and of intrusion or penetration on a physical level, as well as an emotional level, is so great that she gets very critical of the men she's dating. That masks a fear which is very hard to get to in the sessions, because it's so easy for her to rationalize the criticisms. And because she's also very prone to self doubt it's very tricky to question her about why she is being so critical, because she then feels "Oh, what I'm not allowed to make my own choices?" So it's been a very slow and painful process. She's now 36, having been 32 when we started and very aware that she's not much closer than when she started out to making a good relationship with a man. So it would never occur to her to doubt me personally. She is much more likely to feel despair about herself, and it's up to me to bring up the — "What are the other possibilities here, in ways you could be experiencing this? How come you're blaming yourself rather than question me, or working with me to get things more the way they need to be in here?" This is a case in which she should be challenging the process more in order to challenge

> herself more […] I'm doubting myself. Should I be pushing her more? How should I be pushing her more. ***I*** feel the time pressure. I've tried it lots of different ways. I've tried getting her to be more conscious of the goals, like doing writing between sessions, which she ended up not going — this is so often the case. They often just don't do their homework. I've tried doing as intensely as I could, listening for the themes of fear of intrusion or self defense and self doubt which functions ultimately to undermine her terribly in her dealings with people. I'm feeling sort of stuck in a way, just doing what I believe to be the right things isn't really working, so I'm kind of in the middle of it now.

Faced with an impasse, Dr. J talks about her own difficulty handling the impasse:

> I think she should definitely be coming twice a week and she just won't. I've tried lowering the fee, which doesn't feel right to me - she's making a lot of money. It's not about the money. She's just not willing to risk it. It's tricky for me because it feels like blackmail to say, "Look, you're thirty six and you don't have that many more healthy eggs left." It feels coercive with her - it's the sort of intrusion that she fears, people being controlling with her in that way. So it's a bind. … I'm much more aware of what I didn't do well. I had a lot of trouble working with her anger, and that was partly for her need to exclude angry feelings and challenging feelings, but it's also my problem. I have a harder time working with anger and negative transference than I do being nurturing. That's true of me.

While Dr. J claims to have little faith in the psychoanalytic process she uses certain 'tools', such as free association and countertransference as part of the work. Though Dr. J experiences great doubt, she is often

moved by the power of interpreting the unconscious. She stated:

> Recognizing it, formulating it and bringing it into the verbal sphere. And the most recent challenge to that has been working with disassociated patients who can't verbalize, and whose material you can't formulate and interpret in the same way. It gets communicated in the form of enactments rather than communicated in verbal ways. So that's just another way that the unconscious unfolds.

In particular, Dr. J feels challenged in her work with dissociative patients. She explains her thinking this way:

> A lot of what you need to work with isn't there. You're operating to take account of it and to try to move it into the discourse. You don't know what it is, so it is harder. The other thing that's sort of eerie that happens with seriously dissociative clients is that there's a lot of unconscious communication. So one of the ways that I found useful with a few people is if there's somebody who just can't talk, for example. I pay attention to what's going on inside me and I put it into words, and often that frees up the patient, because I'm picking up stuff from her…

Dr. J discusses another clinical example in which her unconscious attunement to the patient coincides with moments of confidence. She says:

> There is a very peculiar self-shift that happens with the dissociative patients. There are large blocks of self-doubt and uncertainty and then moments of complete certainty which are pretty irrational, very grounded in the alliance. I'm thinking about a moment with a very dissociative patient who doubted herself --especially about the incest with her father. I wasn't allowed to talk about it as

something that had happened. She only presented it as something that she was a very bad person to have thought about, and it was all her fault. This is a terrible bind where if she had been incested she would have to kill herself because that would mean she was a really bad person to have had this happen, and if it hadn't happened she would have to kill herself because she would be so bad as to have imagined that it could have happened. For years we went back and forth, me reflecting this kind of dilemma to her like, "should I speak this way with you about this or should I speak that way, and if I acknowledge this that puts us in a terrible position". There came a moment where – she's an artist and she got in the habit of bringing in her work and we were sitting and looking at some of the pictures and I suddenly said to her in one of these moments of certainty "I didn't realize your father wasn't circumcised," because I was looking at pictures of horses heads which so powerfully represented uncircumcised penises to me that I couldn't not say it. Now what that did – that's an example of an enactment where she now had to admit that she knew what her father's penis looked like, and that I had picked this up from her work. That engaged her and grounded her in a reality where she had to admit that the incest had happened. And she then became very frightened, and we had to work through what that meant. But there was a moment that was unmistakable and unavoidable. She had communicated a fact or a reality to me, and that I had understood the reality. The treatment was then moved into the second half, because we could no longer deny that it had happened. So this is an example of an enactment and an experience of certainty which – I mean the moment I said this I thought, "Oh my God, what did I just do?" I forced her to admit or to acknowledge that something had happened, so in a mini-way it was like a re-enactment of the incest – I was forcing myself on her. But it propelled the treatment to a different place. But it rests on a kind of unconscious communication, and my conviction that that happens, and being subject to it, trusting it … I experienced her as making the paintings as a kind of cry for help, and there was a repetitive theme to them of this particular look.

I'd like to suggest that the "certainty" the analyst experience is an activation of her belief in the analytic process.

Dr. J provides yet another clinical example that highlights her reluctant faith. In this example Dr. J is confronted with her own negative countertransference. She describes a case in which the patient had announced that she wanted to terminate. In a session following, the analyst fell asleep. She says:

> It was a horrible surprise for me to discover. And I had to really seriously sit down with myself, and think about what was going on with me. This is a patient who just recently announced that she wants to terminate. And, although it seems ok in that her symptoms are relieved, I discovered that I had all sorts of feelings about this. Because she's a person who's given to contemptuous aggressive attacks, and I think I experienced her announcement as that side of her. I was retaliating by forgetting the session. So this shook me up. Having to look at myself as someone who would retaliate was not fun. It's a side of myself I'm not that comfortable with. And it wasn't easy to — I told her some of this, because I think I owed it to her. It also sort of broke things loose and began to shift things between us.

Even though Dr. J has significant doubts about analytic process, she still manages some aspects of faith. Dr. J uses theory to help her gain understanding of the incident. She says:

> Theory has it that this is the only way that disassociate material can return to the sphere of symbolizing and verbal discourse, so that's kind of a wonderful thing to be able to hang on to, because it means that whatever happens I've used it in some way. This is actually another thing that gives me hope and belief in psychoanalysis - that it's such a creative set of formulations about it — it gives you a way to be creative with things that are destructive. Enactments can cause terrible misunderstandings and conflict if they're not understood and recognized as such, and the psychoanalytic framework is a commitment to making sense out of things that didn't make sense before, which I love. I think it's wonderful.

Dr. J derives nourishment by finding the value and meaning in one's life. In this instance, she speaks about her work with trauma patients, and also brings it to a more personal level. She explains:

> With very traumatized people, the ones who have done famine work and rescue work and that sort of thing, it's different. I don't feel hope for them and their futures, as much as helping them shift to see the value in their lives, and rediscover the worth of what they have done. To be able to draw strength from that. It's a different kind — I don't think of it as hope. It's also true of working with older people. I have several patients who are in their late seventies and they're reflecting now on what their lives haven't been, and coming to grips with the losses and the limits of what they haven't been able to do. And a lot in the work depends on being able to help them value differently what things mean to them, like "You've led a very rich and varied life and a lot of people would admire that, so how come you don't?" So seeking hope is something that I feel good at, which helps me with the trauma work. Feeling the power to reframe the meanings of someone's life or their experience. … Well that's, if anything, what I value about psychoanalysis — the ability to do things and to look at things from all

> different perspectives in a psychoanalytic way is a source of hope in itself. I think it's what I've gained from my own most recent analysis - no matter how despairing I would get my analyst was able to say, "Look what you're doing with this." Even with that kind of a little bit of aggression in her voice. "Why don't you look at it this way, instead of that way?" And that really was very strengthening to me.

**Discussion of Dr. J:**

Dr. J is a psychoanalyst who is quick to doubt herself and admits to avoiding conflict. These aspects of her personality appear to have significant bearing on her belief in the psychoanalytic process. She says "I am beset by doubts — I mean, like individual doubts like, am I on the right track with this person? And kind of general doubts like, is this really what one should be doing with a life?" As is apparent based on Dr. J's interview, we see an instance in which the analyst is truly inspired by her severely disturbed patients, but has little confidence in her own merit. The interface of the two elements leads to the subject's stated lack of faith.

At the start of the interview Dr. J quickly explains the ways in which she does not abide by or believe in psychoanalysis. She reports that she is just as likely to employ other methods of healing to help alleviate patient suffering. And despite this, one gets the sense that Dr.

J's reliance on the unconscious, the concept of enactments and use of countertransference hold a firm place in her psyche and her work. One wonders if Dr. J were able to maintain an analytic mindset, would she have greater faith? Or, if she had a deeper trust in herself, would she be more likely uphold an analytic position?

Dr. J says that while she is "beset by doubts"; she is deeply moved and nourished by her patient's resilience. Dr. J work with severely traumatized adults, relief workers and victims of abuse is framed in the patient's reaping meaning from their lives. As Dr. J notes, " Looking at someone to have a will to live and seeing it in them and seeing their ability to handle some horrendous things is very inspiring. ... I think of PTSD as just a condition of living where the veil has been taken off..." Here we see not only that Dr. J is moved by patient's capabilities of survival, but also she utilizes a perspective of 'reframing' which keeps her from being discouraged.

For many of the subjects interviewed, their analysis was a source of faith. For Dr. J though, similar to Dr. S, reflections on her early analysis were recalled as "disappointing". And in both cases, the analysts' faith appears less consistent than the analysts whose treatments were recalled in a more positive light. Dr. J speaks with

deep resentment towards her first analyst, as she felt he did not help her realize that time was running out for her to have children. She states, "So I hold it against him that he didn't listen to me about this, and wasn't helpful in helping me live my life."

This exact issue reverberates in Dr. J's work with "difficult patients" -- they are women in their thirties who are up against the biological clock. Here we see the analyst's unresolved issues about her own fertility surface and act as an overlay or an over identification with the patient's issue. The analyst's conflict feeds her doubt, which in turn weakens her faith in the process.

Dr. J discusses the case of the 36 year old, childless businesswoman in which the analyst feels the pull to tell her patient what to do, but realizes that this interaction parallels the sort of intrusion that the patient fears. She feels caught in a difficult position "Should I be pushing her more? How should I be pushing her more? I feel the time pressure…". Instead of grappling with the patient's ambivalence about interpersonal relating or acknowledging her overinvestment in this issue, Dr. J shifts her focus to the ways that she has failed as an analyst. I'd like to suggest that the analyst becomes overwhelmed —perhaps by the patient's anger or her own

rage, thus summoning a subjectively unbearable situation, and then doubt. Another possibility is that in her own life, Dr. J put the power in the hands of the analyst that "failed " her; it is this anger and resentment —unresolved issues that block her from accepting responsibility for her life and responsibility for being a therapist.

Dr. J's doubts in the analytic process mirror her own self-doubts. She laments, "I'm much more aware of what I didn't do well. I had a lot of trouble working with her anger, and that was partly for her need to exclude angry feelings and challenging feelings, but it's also my problem. I have a harder time working with anger and negative transference than I do being nurturing. That's true of me." Dr. J also admits that she felt it would be "blackmail" to suggest the patient come more often. This comment indicates the analyst's own ambivalence—she thinks it is actually worthwhile to come more often, but is afraid to ask the patient to do so. Here again, we see the doubt is not about the efficacy of psychoanalysis (in fact, she thinks more is better), but her own role as an authority. Another example of this is when Dr. J lowers her fee for this patient, though she knows the patient can pay more and the issue is not really about money.

Dr. J provides an example in which her negative countertransference towards a patient was expressed by falling asleep in session. Dr. J was dismayed by her behavior, but examined it in the context of the treatment and the therapeutic relationship. Here we see a way in which Dr. J thinks psychoanalytically—her unconscious rage towards her patient was expressed in behavior. This type if framing of a situation shows us that there are certain ways that this subject is analytical.

While Dr. J does not recognize it as such, she uses analytic tools as an expression of faith. In three different clinical cases Dr. J's use of analytic tools facilitated change for the patients. For instance, in the case of one patient, Dr. J discloses her associations to a patient's artwork that opened up an entire area of examination. In this case, it is clear that Dr. J feels that there is value in the countertransference. She talks about the "certainty" she felt as she made a clinical intervention. She said that such an intervention "rests on a kind of unconscious communication, and my conviction that that happens, and being subject to it, trusting it" Additionally, Dr. J provides at least two other examples in which she views the interaction between herself and patient as an enactment—a concept that is firmly rooted in

analytic thinking. Although Dr. J does employ certain analytic techniques and speaks the language of psychoanalysis, she does so inconsistently. This suggests that though she thinks it worthwhile, her doubts overwhelm her beliefs, thus destabilizing her faith in her work.

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**Summary of the Four Interview Selections**

These particular vignettes were chosen because they represent different positions of the experience of faith, the loss of faith and the effect on treatment. Faith, like the analytic process itself has a general , consensual experience which I just discussed by laying out the 6 themes . But, when you look at the specifics of faith and how it functions, important distinctions are present. These vignettes show some of the individual variations.

In the first case, Dr. B presented his work with its foibles, and yet he maintained an analytic perspective throughout. Though he was confronted by patients' anger, lack of progress and hopelessness, they did not develop into subjectively unbearable situations. The analyst reported feeling frustrated and lost at times, but he was not without faith.

In the case of Dr. A, the subject described two different cases in which his faith was engaged. In the first case, a patient missed half of her sessions and the analyst did not interpret this until the end of treatment. According to the analyst, this needed to be "lived-through." The next case though, was one in which the analyst's faith was shaken, as he broke the frame and the patient reacted with anger. It is the second case that he brought to supervision. I would like to suggest that it was the patient's anger that marked a subjectively unbearable situation and caused the analyst's doubt to emerge.

Dr. S was an interesting case because she was someone who voiced passionate belief in her work. Yet a year before the interview an extremely grueling case pushed her to consider leaving the field. In this case, the analyst became overwhelmed by the patient's pain and the way it intersected with her own issues. To this, she sought outside support and hired a supervisor who was able to help regain her therapeutic role and ultimately her faith. Dr.S's own analysis was described as inadequate and may be a factor in her ambivalence about psychoanalytic work.

In the final vignette, Dr. J explained in a variety of ways that she had no faith in the psychoanalytic process.

Though she appreciated the beauty and creativity of the theory, she felt disillusioned. She reported using a variety of non-psychoanalytic techniques to help patients. Possible sources of Dr. J's doubts were connected to her own unsuccessful training analysis, her own unresolved issues that became reactivated when she worked with certain patients and her personality. Dr. J said that she is "beset by doubts," both personally and professionally.

During the interview, Dr. J said definitively that she did not have faith in the analytic process, and yet by the end of the interview it was clear that there were certain elements of analytic work that resonated with her. Though Dr. J said that she has no faith in the analytic process, she still reported using analytic tools to help her gain insight into her patients' lives. By encouraging free association, using her countertransference and framing interactions as 'enactments,' Dr. J remained a reluctant and doubting analyst.

# Discussion of Results

## Overview of Study

This research was conducted with the intention of gaining an understanding of how psychoanalysts define and experience faith the analytic process. Ten analysts were asked to reflect on the experiences of faith; awareness, loss and maintenance of faith in the analytic method and the subsequent effect on clinical choices.

The evaluation of transcripts generated a multitude of issues as outlined in the results chapter. The six themes that were highlighted developed from and were present in all subjects. To further illuminate the specifics of each theme, I presented four vignettes. These vignettes were chosen because they represent different positions of the experience of faith. By presenting the data this way, I demonstrated prevalent themes that are experienced and articulated in both universal and personal ways.

Findings from this research reveal that analyst's faith in psychoanalysis is a dynamic process that becomes engaged in times of doubt or crisis. Those subjects who were able to keep an eye on the significance and metaphorical meaning of a clinical interaction were more

likely to withstand feelings of doubt and maintain the analytic frame. These analysts actively embodied faith in the process. But, analysts who lost their perspective and were inundated by the affective storms inherent in clinical encounters suffered from diminished faith which had a significant impact on their clinical choices.

Specifically and significantly, the data revealed that analysts were more likely to relinquish their therapeutic stance or use of analytic tools (for example, by loosening of the frame, having difficulty in maintaining the metaphor of transference and using fewer interpretations about meaning) when they became overcome by doubt. Analysts "believed" their patients' comments about them and lost sight of their transferential role. This led to the analyst personalizing experiences and working to "correct" a patient's "problems," rather then finding the meaning of them or understanding behaviors as unconscious communication.

When analysts were overcome by crises of faith they were more likely to become directive or supportive with patients. For instance, analysts gave examples in which they referred the patient for a medication consultation, suggested behavioral therapy or used other modalities like hypnosis and art therapy. Additionally, when analysts were

challenged they loosened the analytic frame by letting sessions run longer than the allotted time, becoming lenient about fee or missed sessions or by disclosing personal information.

Analysts were pushed to safe shores by facing their doubts and using the clinical challenges to process with supervisors, analysts and colleagues. After regaining some degree of ego strength, analyst's regained their faith. Paradoxically, the analyst had to simultaneously believe in some notion of psychoanalytic perfection and be able to accept a compromised and realistic view of the process and what it can achieve.

## Summary of Findings

Many of the participants in this research study talked about faith in the analytic process as it related to the patient's potential. They reported feeling hopeful and positive with patients in whom they could locate likelihood for reflection and change. But, when the subjects were asked to provide clinical examples of moments when faith was an issue, they all gave examples of when they were tested personally. As mentioned above, one would expect that based on the number of subjects that underscored the

importance of the patient's potential, clinical examples would be filled with situations in which the *patient* overcame challenges. Instead, all of the subjects responded with clinical experiences in which *they* were tested and challenged by subjectively unbearable situations.

Subjects described the circumstances that elicited doubt— subjectively unbearable situations--in a way that could be categorized in three different ways. They are:(a) the patient's lack of progress, (b) the analyst's difficulties that were engendered by personal history or the patient's behavior and (c) situations in which the analyst and patient are poorly matched.

When analysts were confronted with these subjectively unbearable experiences, a type of cognitive collapse occurred and the analysts lost sight of their role. Analysts who felt psychologically unsafe tended to compromise the analytic qualities of treatment in various ways. The data shows that analysts were more likely to relinquish their therapeutic stance or use of analytic tools when overcome by fear or doubt (see Appendix B, Table 5). In turn a crises of faith developed and seemed to be remedied only by interactions that supported the analyst's sense of self. Subjects reported that they turned to

colleagues, supervisors and analysts for support. Subjects also reflected on their work, recalled difficult storms they had weathered with the patient as reminders of their endurance. Some of the analysts returned to theory, reading the works of famous, more seasoned analysts. And finally, analyst's used various forms of self-care to keep their faith in line. In all of these cases, the subjectively unbearable situations became more bearable through reflection, processing, and containment.

Analysts' personal experiences appeared to have significant bearing on their ability to maintain faith in the analytic process. The reflections of the psychoanalysts I interviewed suggest that faith is developed through personal experiences of being able to bear difficult feelings. Analysts whose own training analysis addressed and resolved key issues were better able to trust the analytic process. In particular, analysts who had positive analytic experiences were able to internalize aspects of the process and then call on this to sustain them. Also, the analysts were able to identify with their own analyst's stance and containment of them, and the memory of this type of interaction serves as a vital resource.

Subjects who felt 'failed' by their analysts were skeptical about the usefulness of psychoanalysis. They were

more likely to employ analytic tools arbitrarily or use them and relax them more quickly. Additionally, analysts who felt they had been unable to manage a particularly difficult issue in their own lives had difficulty helping a patient do the same.

Another finding is that personal characteristics and temperament have some bearing on analyst's faith in the process. Some people are basically more hopeful and optimistic than others. Certain aspects of their personality structure lend themselves more easily to trusting in the process.

Interestingly, all of the subjects conveyed a deep respect for analytic theory. None of the analysts suggested that they were failed by the theory, but rather by their personal limitations and the realities intrinsic to being human. Even those subjects who did not believe in themselves as psychoanalysts were able to appreciate the exqusite and complex aspects of the theory. Analysts lapses in faith are lapses in belief in themselves, not the psychoanalytic endeavor. Therefore, we can consider crises of faith in the analytic process have more to do with crises in believing in one's self and one's abilities to utilize the analytic method to its utmost.

When psychoanalysts' faith was affirmed by productive clinical encounters, analysts experienced joy and then knowledge. They talked about the "beauty" and the "uplifting" nature of their work. Additionally, the consistent use of psychoanalytic tools provided faith to analysts in times of need because of their effectiveness. It seems that faith both supplies strength to the analyst and also replenishes it, thus helping people go through new, difficult experiences that appear in the present and in the future.

At the start of this research project, I was faced with a the question of whether the analyst's faith protects the use of analytic tools and therefore the analytic process? Or, does the implementation of analytic tools protect the analyst's faith? The answer appears to be 'both'. The frame helps establish faith and faith helps maintain the frame.

Ahktar's idea of "borrowed faith" (2006) seems an accurate appraisal of how faith initially becomes internalized by the analyst. At first, the analyst relies on external support of teachers and colleagues to help her trust the analytic method. After accumulating experiences in which the analytic tools have been put to use and prove valuable, the analyst begins to define her own sense of

faith. Over the course of a career or a treatment, the analyst is likely confronted with subjectively unbearable experiences that activate her doubt. In the wake of such uncertainty, the analyst is less likely to adhere to the analytic frame. As a result, the crisis of faith becomes full-blown. The analyst doubts herself and the reinforcements provided by the analytic tools are no longer useful. If the analyst is aware of this, she looks for external support through supervision, personal analysis or collegial relationships. Here, the analyst wrestles with her doubts, consolidates the shaken aspects of self and regains an analytic stance. The analytic tools help preserve the analyst's faith because they allow the analyst to put an optimal distance between her private self and professional role by creating a frame around the therapeutic interaction. In doing so, the analyst can reflect, use theory and be less personally involved.

## Implications for Clinical Work

Subjectively unbearable situations are a risk of this work and a vital aspect of it, as well. They are not to be avoided. What this means though, is that analysts need to establish personal and professional support systems to help

them tolerate situations. Analyst's reliance on supervisors, colleagues, the analytic community and personal analysts are all good sources of support.

The analyst's own treatment or supervision is vital, where details of a case can be discussed and considered deeply. The more the analyst is aware of her own conflicts and issues, the more she can watch for potential ruptures in a treatment. Additionally, the more positive therapeutic interactions the analyst has had, the more she can rely on those to sustain her belief.

This study shows us that though theory is an important aspect to our work, it is the human experience of being able to bear discomfort that essential to sustaining analyst's faith in their work. With this is mind, training should respect and focus supervision and learning opportunities that allow the training clinician to voice the "unspeakeable"— their fear, anger and confusion. Furthermore, supervisors should also understand the importance of reminding the student about the power of the frame. In this way, the supervisor provides the strength, knowledge and faith that the student has yet to accumulate. As the student makes use of the analytic tools, she will begin to acquire experiences which will become internalized and provide the reserve of faith needed for later in her

career.

## Limitations of the Study

The interview method was semi-structured and highly confidential. Subjects shared deeply personal experiences and allowed for an affective honesty to be revealed. While the data may not have the precision of a quantitative study, what this study does offer is a deep, nuanced and complex view of the topic. Since the focus of this study was a comprehensive exploration of a specific topic, a small sample size was used. In addition to being small, the sample was not randomized, and the results of this study therefore cannot be generalized to a larger population of psychoanalysts.

Another limitation (and also a strength)is the use of self-reporting narrative data as the methodology of a study, in that it is dependent upon the subject's perspective. The data is subjective and necessarily uncorroborated. Additionally, the impact of a subject's personality and character structure likely had some bearing on their responses. If an analyst were depressed or pessimistic, his answers would differ from someone more grandiose, or his own thoughts at another time. Likewise,

subjects may have felt defensive about certain trains of thought and censored themselves as a way to protect against feelings of vulnerability.

Another limitation to this study was the self-selective nature of it. The participants used in this study were psychoanalysts who volunteer and were willing to discuss personal experiences with regard to faith in the analytic method. As such, we can assume that this unique population is distinctive for being introspective. They are used to thinking about and discussing such subjects as hope and despair. This may enable a more natural flow of ideas to surface, but runs the risk of rote, stale thinking. Additionally, subjects may have spoken protectively about their faith in the analytic method, as they had committed many years and substantial amounts of money towards their career choices. These dimensions may have made it more difficult to separate out some of the issues around this topic.

The fact that the investigator was a clinician may also have some bearing on response styles. Participants could have been more reluctant to reveal information or appear in a negative light, for fear of being analyzed or other repercussions.

## Suggestions for Future Research

The data collected from psychoanalysts was intricate and sophisticated, thus suggesting that this cohort is a good source of information about philosophical and humanistic topics. As noted in the literature review, there are a number of theoretical papers that have begun to grapple with the issues of faith and hope in psychoanalysis. A larger scale study could be helpful in identifying patterns in the narrative data of psychoanalysts. This present research could be used to devise a questionnaire for a larger-scale quantitative study.

Another possibility for research on this topic is to conduct a longitudinal study so that outcomes could be measured. While this study did bring some significant themes to the fore, it is difficult to know the meaning of them without a follow up study. Additionally, a long-term study would be useful in tracking analyst's faith and their relationship to their work over the course of their careers. Although the pool of subjects was small, the importance of faith in the psychoanalytic process is

embedded in the psychoanalytic literature and practice, and faith may well be an indicator of the efficacy of the work.

An attachment related study that would evaluate analyst's attachment styles in relation to their faith in their work would also be interesting. If an analyst's secure or insecure attachment to belief in their work is related to their attachment to their training analyst or other primary objects effect analysts clinical choices could be rich. This study did not provide enough accurate data on this topic.

## *APPENDIX A*

**Interview Protocol**

On the phone: Maybe you can think of some experiences when a patient struggled with a crisis of faith. (How do they pose a challenge to your faith) and examples in which patient had faith…"

PI " I am interested in examining clinician's faith in the psychoanalytic process. I am going to ask you to discuss both professional and personal aspects of faith. Remember that you have the right to withdraw consent and discontinue participation at any time. I will be taping the session and it will last approximately 1:30 minutes."

**General information**

Subject code:

Age:

Degree:

Level of training/ Years of clinical practice:

Type of practice:

Primary theoretical orientation:

**Clinical Experience**

If you reflect back on your work as a psychoanalyst , can you tell me to what extent faith is a necessary component in the psychoanalytic process?
Example?

Can you discuss an experience with a patient in which faith was an issue?
Example?

If your faith was nourished, what are some of the factors that may have contributed to it?
If your faith was challenged, what are some of the factors that may have contributed to it?
Can you tell me why this may have come to mind?

Many analysts go through cycles in their work, Can you tell me an experience in which you had a crisis of faith in your work?
What in particular colored the situation?
What, if anything, pulled you through ? Was your faith restored?
How did you handle this with the patient? Did you express your concerns?

Generally speaking, what role do you think hope plays in psychoanalysis?
Example?

Are you aware of hopes for your patient and/or self during a treatment?
Example?
How do you become aware of them? Do the effect your interpretations?
Do these change over time?

In your work as a clinician, what circumstances/types of patients make you feel most hopeful?
Example?
Are there patients with whom you feel hopeless? Why may that be?

In your opinion, what's the difference between hope and faith?

What kind of patients do you find most difficult tot work with? And what role does hope and faith play? Example?

How do you sustain hope and faith in the psychoanalytic process with even the most disturbed patients?
Example?

**Personal Experience**

What do you think is (are) your source (sources) of faith in analysis?

Anything important for me to know that bears on this topic? Anything about you or your history that may inform your views?

Is there an event or relationship that you refer to and reflect on when your faith is affected?

Has your own analysis influenced your belief in this work?
If yes, has something occurred that helps support your view of self as clinician?

Mentors who have instilled faith?

Have you found that the times in which you are in crisis personally—times when you may feel hopeless in your civilian life---has this affected your belief in the analytic process?

**Development of Faith and Hope**

How do you see your faith in the therapeutic process changing over time?
Are you more or less hopeful as time has progressed?
What may be some of the reasons for this?

What specific aspects of the psychoanalytic endeavor do you have faith in? (self/process/relationship)

What about when there are surprises in your work?
Has that affected your faith over time?

What extent do you think your faith in the method affects treatment?
Example?

Are there ways in which faith and hope may hinder your work?
Can you discuss a clinical example?

Many clinicians go through times when their faith in the psychoanalytic process wanes. Does that happen to you? To what extent does it affect your work?

**Technique/Theory**

In your theoretical framework, is there a view about faith/hope?
Technique as a way to deal with crisis?

**Debriefing of Interview Process**

In what ways, if any, do faith/hope figure into your life?

Anything else come to mind about topic that might be useful?

When you think about it now, is there anything you'd like to add about definition of faith/hope?

How have you felt discussing this topic?

**Faith and Hope in the Psychoanalytic Process**

**PARTICIPANT CONSENT FORM**

Name_____
Date_____

I understand that the purpose of the study is to explore my experience of faith in the psychoanalytic process and the implications for my use of technique, theory and commitment to my work. Further, I know the study will focus on various aspects of my professional and personal life.

If I choose to take part, I agree to meet with the interviewer for approximately 1.5 hours to discuss my experience of my career as a psychoanalyst.

I understand that my responses to all of the interviewer's questions will be tape recorded and will remain confidential. On the tapes I will only be identified by a participant identification number. I will not be asked my name, address or phone number during the taping but I will be asked to provide the information on a separate sheet of paper. I understand that this information will be kept separate from the interview tapes. By signing this form I agree that I am willing to be contacted in the future for possible interviews although I am under no obligation to participate. I understand that I will have the opportunity to review the written transcript of the interview, if I so choose.

While I may find the interview interesting and learn something about myself from it, I understand that the purpose of this research is not for my immediate benefit. I have been given the opportunity to ask any questions I have about my participation in this study. I understand that my participation will not subject me to any physical risk or significant psychological distress. Further, I have been informed about the system for insuring my confidentiality and have no concerns on that matter.

Since my participation is voluntary, I understand that I can stop at any time.

I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. If I have any questions or complaints about my rights as a

subject, I may call Ethel Breheny or Christina Giradis, Institutional Review Board Administrators, at 212-650-7903 during office hours. If I have any further questions about the study, I may call Erika Goldberg at 212-650-6602 or Dr. Elliot Jurist, Professor of Psychology at the City College of the City University of New York at 212-650-5720. I have been given a copy of this form to keep.

I agree to participate in this study.

_____ _____

Signature Print Name

## APPENDIX B

| **Table 1. Clinical situations that challenge analysts' faith** |
|---|
| Patients who do not talk/ Remoteness |
| Patients who are enraged |
| Patients who seek outside consultations |
| Patient who consistently misses sessions |
| Patients who are self-defeating |
| Patients who lack empathy/sociopathic |
| Patient appears to decompensate and may need hospitalization |
| Patients addicted to drugs or alcohol |
| Analyst's rageful feeling towards patient |
| Analysts' overwhelming self-doubt |
| Analyst's loving feelings towards patient |
| Analyst's lack of a plan/ ambiguity within analytic work |
| Analyst overidentifies with patient's issues |
| Analyst is confronted with issue in patient's life that is unresolved in their own life |
| Environmental factors that forclose change ( partner who won't change, women in their 30's who want children…) |
| Threat of abrupt termination or abandonment of analyst |
| |

| **Table 2. Clinical situations that strengthen analysts' faith** |
|---|
| Patients who can consciously work on themselves |
| Patients who are young (teenagers, early 20's) |
| Patients who have a sense of humor |
| Patients who are attractive to analyst (physically or psychologically) |
| Patient who is able to enjoy life |
| Analyst identifies with circumstances in patient's |
| Analyst identifies with patient's dynamics/psychological struggles |
| Analyst feels he has an impact on patient |
| Analyst sees obvious improvement in patient's life |
| Analyst understands the treatment |

| **Table 3. Non-Clinical situations that strengthen analyst's faith** |
|---|
| Supervision |
| Peer Group |
| Processing with Colleagues |
| Reading theory |
| Self-Care; adequate fee, adequate vacation |
| Self-reflection on personal enrichment of work |
| Framing interactions in terms of enactments, transference/countertransference |
| Teaching or supervising students |
| Maintaining or adjusting goals to be realistic |
| Referring difficult patients to colleagues, who then go on to have productive treatments |

| **Table 4. Sources of faith in the analytic process** |
|---|
| Personal analysis |
| Accumulated successful analyses of patients |
| Identification with patient's struggle |
| Analyst's 'hunch' or 'gut feeling' confirmed |
| Identification with early objects (parents, friends, teachers) |
| Religion |
| Personal Philosophy |
| Uncertain |

| **Table 5. Lack of faith and its impact on technique** |
|---|
| Analyst loosens of frame; increased sessions, increased time, intervention outside consultation room |
| Analyst looks to other methods; CBT, medication, hypnosis, art therapy |
| Analyst becomes more directive |
| Analyst becomes more supportive |
| Loses sight of transference; analyst takes patient's comments personally |
| Loses sight of countertransference; analyst takes own feelings about patient as 'real' |

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