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**CHANGE IN
PSYCHOANALYTIC
TREATMENT**

Curative Factors in Dynamic Psychotherapy

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Change in Psychoanalytic Treatment¹

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What do we mean by change in psychoanalytic treatment? I believe we would all agree that basically one of the things which distinguishes the goal of psychoanalytic treatment from that of most other therapies is that it aims not simply at removal of symptoms but at basic characterological change. Whether these changes are subsumed under the concept of genitality, as in libido theory, or under such concepts as self-realization or the full development of the self, I believe it is clear that they are concerned with basically similar goals of improving the ego-adaptive capacity of individuals, of helping them to achieve greater emotional maturity, to love unselfishly, to have meaningful and satisfying sexual relationships, to work effectively, and to be socially responsible and productive human beings within the limits of their capacities. Although these are ideal goals, any movement in the direction of these goals is what we mean when we speak of change as a result of psychoanalytic treatment.

Traditionally and historically, change in psychoanalytic treatment has always been ascribed to one of two factors, or to a combination of the two: (a) increased cognitive awareness via the insight or the interpretations that the analyst made to the patient; and/or (b) the release of repressed affect, which

Freud called abreaction. Freud linked abreaction to the recall of infantile traumata and the release of affect bound up with these traumata. Ideally, change in analytic treatment has been considered most likely to occur with a combination of cognitive awareness and release of affect, or so-called "emotional insight."

As time went on, however, the concept of the analytic process became more complicated, not necessarily in terms of its essence, but with regard to how this goal could be achieved. First and foremost, Freud himself gave up the idea that abreaction or cognitive awareness, in and of itself, was sufficient to achieve analytic change, and placed increasing emphasis on what he called the "working through" of resistances. He conceived of these resistances primarily as resistances to remembering the repressed infantile memories whose recovery he considered essential to analytic change. Gradually, however, a number of other tenets became tied to the concept of analytic technique and change in psychoanalytic treatment. For example, it was considered important to maintain a certain level of tension during the analytic hour by means of some frustration of the patient. The use of the couch, of course, was traditional. Sessions were expected to be daily, if possible, but under no circumstances to be less than four times a week for "proper" analytic therapy. Great emphasis was put on the "correct" timing and content of interpretations in achieving analytic change. The analyst ideally was expected to maintain the "neutral mirror" model, which involved

a certain degree of passivity, the maintenance of analytic incognito, and the maintenance of a value-free attitude of neutrality with regard to moral judgments. Later analytic theoreticians placed great emphasis, also, on the promotion of regression in the analytic technique, and on the revival and reliving of the infantile neurosis as an essential element in achieving psychoanalytic change in treatment. Finally, in more recent years, there has been an increasing recognition of the importance of countertransference factors in the analytic process, but their actual role in achieving change in psychoanalytic treatment has never been clearly delineated.

Over the years, as my own experience with analysis and analysts grew, I found myself troubled by a basic question. If "correct" cognitive interpretation and "correct" cognitive insight were key factors in analytic change, why was it that patients seemed to respond favorably to analysts with disparate theoretical views? Certainly, it seemed to me, there had to be some common denominator that underlay the different schools of analytic thought, all of whom were helping their patients, as far as I could tell. Moreover, why did I have the impression that colleagues who adhered strictly to the "neutral mirror" model seemed, on the whole, to do less well with their patients than those who related more warmly, actively, and empathically? Third, I found myself questioning, more and more, whether it was actually ever possible to be totally neutral or value free in the analytic situation. Did not our very focus on what we interpreted as healthy or neurotic, mature or

immature, appropriately masculine or feminine, bespeak certain values which we were reflecting as products of our own particular cultural context? Fourth, I found myself asking whether the insights for which we strove and which we considered indispensable to the achievement of change in psychoanalysis were really so indispensable. Finally, I must take note of the important influence upon my thinking of the Alexander and French book (1946) on psychoanalytic therapy, with its emphasis on the principles of flexibility and its concept of the corrective emotional experience as a significant factor in analytic change.

My admiration for Alexander's thinking ultimately led to our friendship and to my participation with him and several other colleagues in a four-year research study, beginning in 1957, on the nature of the psychotherapeutic process as practiced by psychoanalysts. As many of you know, this was a study in which the transactions between several experienced psychoanalysts and their patients were observed through one-way screens and meticulously recorded by other analysts over a period of several years. A basic premise of this study was that no analyst or patient could adequately observe or describe what went on in their work together because their involvement in the process itself precluded their being able to do so with true objectivity—only an outside observer could be expected to accomplish this. Before that time it had been assumed generally that such observation would introduce an impurity that would seriously modify or alter the observed process, but we found—

what we all know now—that, except for some initial self-consciousness on the part of both therapist and patient (more the therapist!), the psychotherapeutic and psychoanalytic processes went on as usual.

In brief, I think it is fair to say that probably the single most important awareness that emerged from this study was a recognition of the subtlety, multiplicity, and complexity of the interacting variables, *both verbal and nonverbal*, that enter into the psychoanalytic process. What we had previously thought of as something that an analyst did for or to a patient was actually a complex transactional process taking place *between* them, with the analyst's particular "techniques" being only one of many factors involved. Indeed, over the years, I have come to the conclusion that these variables enter into all psychotherapeutic processes, nonanalytic as well as analytic, but for the purpose of this discussion I will focus only on change in the analytic process.

Let me begin by stating the obvious (although it sometimes seems to be overlooked in the psychoanalytic literature). Psychoanalysts are not uniform, interchangeable units like safety-razor blades. Not only do patients differ—e.g., in the nature of their psychopathology, their ego strengths and ego defenses, their capacity to verbalize, their values, their motivation to change, their life situations and support systems—but so do psychoanalysts, e.g., in their capacities for warmth and empathy, their style, knowledge, appearance,

sophistication, reputation. Add to these the disparate conscious and unconscious emotional needs, ambitions, and value systems of different analysts, and we begin to get some inkling of the numerous variables and transference-countertransference reactions that play a fateful part in the outcome of every psychoanalytic process. Taken all together, these constitute the complex network of elements that shape the patient-therapist relationship that is the fundamental matrix of the analytic process and critical to its success or failure in producing change. I wish to emphasize that these elements encompass not only unconscious factors but also the real attributes—physical, psychological, and situational—of both patient and therapist. Basic reality obstacles can defeat even the best analytic technique.

Although a good patient-therapist relationship is probably the single most important factor producing change in psychoanalytic treatment, there are other factors that play significant contributory roles.

We are all aware of the therapeutic value of catharsis, particularly in the opening phase of the analytic process. This term, coined by Freud, reflects his concept of it as a discharge of repressed libidinal tension. To appreciate its meaning within an ego-psychological framework, however, we must recall that it takes place in the context of the troubled patient's faith, hope, and expectancy of receiving help from the analyst whose social role carries the promise that such help can be forthcoming. I believe that what holds true for

catharsis also holds true for the phenomenon of abreaction. We all know by now, as Freud was the first to discover, that abreaction in and of itself is not necessarily therapeutic. Yet the belief in its value continues to persist in countless forms of contemporary therapies. The reason for this, I believe, is not in its function as a discharge phenomenon, but rather that an atmosphere of heightened suggestion and expectation that improvement will occur can indeed produce feelings of well-being.

One of the primary distinguishing features of the analytic process is its effort to uncover and identify the unconscious psychodynamic factors, both past and present, that lie behind the patient's adaptive difficulties. Although many other forms of psychotherapy may occasionally employ aspects of this approach, the emphasis on it is uniquely psychoanalytic, as are the techniques of transference- and dream-interpretation as major ways of achieving it. Such understanding, which we term "insight," has generally been considered essential to achieving change in psychoanalysis. Over the years I have come to question this assumption for the simple reason that again and again I have encountered patients who have clearly benefited, both subjectively and objectively, from their analytic treatment without any clear cognitive conception of how or why this improvement has taken place.

Moreover, as I have indicated, the "insights" that patients receive from adherents of different analytic schools vary greatly, so that the specific form

of the insight cannot be considered essential for change to take place. Finally, we have all seen patients who seem to have considerable cognitive awareness of the basis of their difficulties, but who fail to change behaviorally. The least we can say in such instances is that insight alone is not enough.

I would not want these brief remarks to be interpreted as meaning that I place no value on insight in the analytic process. If there were no reason other than that it represents an effort to create a rational foundation for the understanding of how and why psychopathology develops, and thus is part of scientific tradition, I would consider it indispensable. But, over and above this, I believe there is reason to believe that therapeutic results achieved with the aid of insight have a more solid underpinning and are more likely to be lasting. A number of comparative studies of behavioral versus psychodynamic therapies have demonstrated that, although results are achieved more quickly with certain behavioral approaches, they tend to last longer after insight-oriented psychotherapy.

If changes in psychoanalytic treatment do not necessarily depend on insight, what other elements are involved? I believe that there are four other important factors that contribute to change in analytic treatment: (1) operant conditioning, by means of explicit or implicit approval-disapproval cues from the analyst as well as via corrective emotional experiences in which the analyst's responses to the patient's maladaptive behavior differ from those

experienced at the hands of significant figures in the patient's developmental past; (2) suggestion and persuasion, usually implicit, rarely explicit; (3) identification with the analyst; and (4) repeated reality-testing or practicing of new adaptive techniques, both in the analytic situation and in the outside world, in the context of consistent emotional support from the analyst.

The recognition that the analytic process involved a significant amount of operant conditioning was one of the important discoveries that emerged from the aforementioned research study that Alexander and his colleagues undertook in the late 1950s. One of our major observations was the striking degree to which the analyst's values and therapeutic goals were conveyed nonverbally, even when care was being taken not to express them verbally. Facial reactions, a look of approval or disapproval, a slight lift of the eyebrows, a barely perceptible nod of the head or shrug of the shoulders, became important channels of communication to the patient. Even behind the couch, the subtle nuance of an mm-hmm, the pattern of the silences, the analyst's shifting movements, or the tonal quality of comments served as cues to the patient whose antennae were highly sensitive to the slightest indication of interest or lack of interest, approval or disapproval. Other studies around the same time (Krasner, 1958; Mandler and Kaplan, 1956) were able to demonstrate experimentally that such minimal signals not only acted as a subtle operant conditioning system—reinforcing approved thought and behavior, and discouraging that which was disapproved of—but also clearly

influenced the content of the patient's communication.

Although nondirective analytic treatment presumably eschews suggestion, the latter weaves willy-nilly like a continuous thread throughout the therapeutic process. The patient's expectation of being helped, the implication that such help will be forthcoming if there is compliance with the analytic program, and the analyst's every indication that certain patterns of behavior and thought are healthier or more mature than others involve implicit, if not explicit, elements of suggestion and persuasion. The greater the degree of positive transference, the greater the faith, hope, and expectancy, and the more responsive the patient is apt to be to these cues.

Another unexpected finding from our extensive observations of analytic treatment was the surprising degree to which patients unconsciously tended to adopt certain of the analyst's patterns of thought and behavior after a while. This process occurs without the analyst's consciously intending it or fostering it and is often described as a form of identification. Strachey (1934) attributes it to what he calls "dosed introjects of the analyst's superego" (p. 159). Miller and Dollard (1941) would probably consider it just another form of social learning.

Finally, the process of repetitive reality testing is one of the critical factors in achieving change in analytic treatment. Although Freud originally

applied the concept of "working through" to the laborious and repetitive process of overcoming the patient's resistances to the uncovering process in analysis, more and more ego-oriented analysts have been applying the term to the equally laborious and important task of overcoming the patient's resistances to change, in terms of the achievement of new patterns of thought and behavior. Neither insights nor confrontations nor transference interpretations, in and of themselves, necessarily produce fundamental change, although occasionally we may be gratified to see change occur on that basis alone. More often than not, however, particularly in the treatment of difficult character disturbances and of severe phobic reactions, we find it necessary, sooner or later—as Freud himself (1919) was the first to note—gently and persistently to begin to encourage the patient to come to grips directly with the anxiety-provoking situation, and by a series of graduated successes eventually to achieve the desired sense of mastery. For most patients this does not come easily; there is much resistance to giving up their long-established defensive patterns. Analytic work usually takes years not because the uncovering process takes that long but because the process of enabling the patient to generalize the insights achieved in the transference situation and to apply them to the wider arenas of his life does not usually come easily and requires patient, repetitive interpretation of perceptual distortions and defensive rationalizations under an umbrella of benign and consistent emotional support.

To summarize what I have said thus far, I believe that the elements that produce change in analytic treatment can be subsumed under the following main categories:

(1) A basic matrix of a good patient-therapist relationship resting on both real and fantasied qualities that each brings to their work together—e.g., the therapist's real abilities, values, genuineness of interest, empathy, and respect for the patient; and the patient's belief system, expectancies, motivation to change, and capacity to relate. This matrix includes both conscious and unconscious elements, and encompasses such concepts as "rapport" and "therapeutic alliance," in addition to the transference-countertransference aspects of the patient-therapist relationship.

(2) Release of emotional tension. This encompasses the concepts of both catharsis and abreaction associated with being able to remember and discuss with a helping person painful memories and feelings within the context of heightened expectations and hopes that help will be forthcoming.

(3) Cognitive learning, or the acquisition of insight into the nature and sources of the presenting problem. This insight may be presented in the context of a number of different theoretical frameworks—Freudian, neo-Freudian, Jungian, etc.—and still be effective as long as the other therapeutic elements are operative also. That is, the specific content of the insight is in

itself not essential to the change process as long as it presents a plausible and internally logical explanation for the patient's difficulties.

(4) Operant conditioning, by means of subtle and often nonverbal cues of approval or disapproval, as well as by corrective emotional experiences in the relationship with the analyst.

(5) Suggestion and persuasion, usually implicit, occasionally explicit.

(6) Unconscious identification with the analyst, both conceptually and behaviorally.

(7) Repeated reality testing and "working through" in the context of the analyst's sustained and consistent emotional support.

Although I first presented these ideas in 1962 and 1964, various other similar models have since appeared in the literature. To mention only a few, Hans Strupp (1976, p. 97) describes three basic "conditions" for therapeutic change: (1) a basic helping relationship "created and maintained" by the therapist, and characterized by "respect, interest, understanding, tact, maturity, and a firm belief in his or her ability to help"; (2) condition one provides what Strupp calls "a power base" from which the therapist can influence the patient through (a) suggestion and persuasion, (b) encouragement of communication and honest self-scrutiny, (c)

interpretations of unconscious material, (d) providing a model of maturity, and (e) manipulation of rewards; and (3) the third condition is that the patient have both the "capacity and willingness to profit from the experience."

Jerome Frank (1976, pp. 83-85) believes all therapies, including analysis, share six therapeutic functions:

- (1) Strengthening the therapeutic relationship.
- (2) Inspiring the patient's hope for help.
- (3) Providing opportunities for both cognitive and experiential learning.
- (4) Stimulating emotional arousal as a motive power for change in attitudes and behavior.
- (5) Enhancing the patient's sense of mastery and competence by providing or stimulating success experiences.
- (6) Encouraging "working through" and the application of what has been learned in therapy to daily living.

Finally, Jules Masserman (1980, pp. 86-89), with his usual felicitous turn of phrase, has recently described the basic ingredients of therapeutic change in what he calls the "Seven Pil-R's of Biodynamic Therapy":

- (1) Reputation of the therapist

- (2) Rapport
- (3) Review of the history—assets as well as liabilities
- (4) Reconsideration and reorientation
- (5) Reeducation and rehabilitation (recycling)
- (6) Resocialization
- (7) Relief of symptoms

Before bringing this discussion to a close, there are a few other issues that I would like to touch on briefly as important ingredients in producing change in analytic treatment.

The first of these is warmth. Numerous studies have experimentally confirmed the fact that therapists who convey a quality of empathic warmth to their patients consistently tend to achieve better therapeutic results. This finding has an important bearing on the therapeutic usefulness of the impersonal "neutral mirror" model in classical analytic technique. This recommendation of Freud's had great merit in the context in which it was originally made—namely, at a time when he was exploring the still totally uncharted area of the "unconscious" and therefore wanted to exclude, as much as was humanly possible, any external "impurities" from the pristine free associations of his patients. What is good for research, however, is not

necessarily good for treatment, and from all that we have now come to learn about the nature of the therapeutic process, it seems safe to say that a strictly impersonal and "neutral" approach to our analytic patients is not conducive to the best therapeutic results. It goes without saying that this does not mean that an analyst should react to patients with unprofessional effusiveness or seductiveness. It does mean, however, that the ability to transmit to our patients feelings of empathic warmth and genuineness of interest within the context of professional objectivity *is* an important ingredient of the therapeutic matrix. Incidentally, it is worth noting that, from all we know about the way Freud actually practiced, he *did* convey these qualities, despite his written emphasis on the mirror model.

The second issue is the importance of the therapist's being an active rather than a passive participant in the analytic process; by this I mean being a participant observer (as Sullivan [1953] put it) rather than a passive one. Obviously, this does *not* mean acting out in the analysis, indulging in wild analytic interpretations, or being directive and telling the patient what to do. It *does* mean actively confronting defenses and resistances, responding empathically to patient distress without forsaking objectivity, and never losing sight of the fact that the goal of analysis is not the interminable exploration of primary-process material as an end in itself, but the utilization of all insights toward the focused goal of enabling patients to cope more adaptively with their problems of living. This is a point that Leon Salzman

(1976) has also emphasized. The understanding received from transference and dream interpretations *must* be translated wherever possible into more generalized applications to other situations and other interpersonal relationships; otherwise, there is a danger that they will remain sterile and useless. This kind of activity on the part of the therapist serves a number of constructive therapeutic purposes: (1) it is an indication to the patient of the analyst's concern and interest both in the patient and in the therapeutic objective; (2) it maintains a high level of therapeutic tension more effectively and constructively than does the old rule of frustration; (3) it helps to maintain a therapeutic focus and does not allow the patient or the analytic process to lapse into long and sterile periods of silence, passivity, or fruitless digression. Thus it tends to promote therapeutic change more rapidly, on the whole, than does a classically passive technique.

Finally, over the years I have come to appreciate the great importance of setting a termination point to the analytic process. The first analyst to set a termination date in analytic treatment was Freud (1918) himself in his treatment of the Wolf Man in 1912. Subsequently, Ferenczi and Rank did considerable experimenting with it and, indeed, Rank made it one of the cornerstones of his therapeutic method. In the late 1940s Franz Alexander called attention to it again as an important technical device, and more recently, a number of psychoanalysts, notably Sifneos (1972), Mann (1973), and Malan (1976), have made it the central feature of their short-term

psychoanalytic therapeutic techniques.

In recent years, particularly since the germinal research work of Mahler (1968) and Bowlby (1969, 1973), the central importance of the separation-individuation issue has come sharply to the fore, not only in human personality development but also in the analytic process itself. As a result we have become more aware of the dependency elements that are potentially involved in the analytic process itself, and the entire issue of analysis, terminable and interminable, takes on a new dimension. Alexander was one of the first to point out that the very process of daily visits in analysis can foster an unhealthy dependency in some patients, and Rado (1956) indicated that the fostering of regression in classical analytic technique can have a similar result.

What I am indicating circuitously is that occasionally we analysts are somewhat remiss in prolonging the treatment of our patients more than is absolutely necessary. If we are totally honest with ourselves, it may be that occasionally the conflict of interest that is inherent in the fact that we have a stake in keeping our schedules filled plays a role in this state of things. But putting this aside, I merely want to call to your attention the psychodynamic value of the analyst's setting a termination date at some suitable point in the analytic process rather than waiting, as is traditionally done, "for both patient and analyst to somehow arrive at such a conclusion mutually." When the

analyst sets the termination date, it inevitably brings the issue of separation and individuation to the fore in a way that can no longer be conveniently avoided or ignored. The analytic work becomes more sharply focused on that issue and on the dissolution of the transference. The setting of the date conveys another important message. It implicitly says to the patient: "I, the analyst, now have sufficient confidence in your strength and capacity to function autonomously that I can cut you loose." Although the initial reaction of patients is one of separation anxiety and even feelings of rejection, once these feelings have been worked through, patients usually take a giant step forward in self-confidence and autonomy. Thus, letting the patient go is the final and quintessential therapeutic maneuver in the production of change in analytic treatment!

REFERENCES

Alexander, F., & French, T. M. (1946), *Psychoanalytic Therapy*. New York: Ronald.

Bowlby, J. (1969), *Attachment and Loss, Vol. I: Attachment*. New York: Basic Books.

____ (1973), *Attachment and Loss, Vol. II: Separation*. New York: Basic Books.

Frank, J. (1976), Restoration of morale and behavior change. In: *What Makes Behavior Change Possible?*, ed. A. Burton. New York: Brunner/Mazel, pp. 73-95.

Freud, S. (1918), From the history of an infantile neurosis. *Standard Edition*, 17:7-122. London: Hogarth Press, 1955.

____ (1919), Lines of advance in psycho-analytic therapy. *Standard Edition*, 17:157-168. London:

Hogarth Press, 1955.

Krasner, L. (1958), Studies of the conditioning of verbal behavior. *Psychol. Bull.*, 55:148-170.

Mahler, M. (1968), *On Human Symbiosis and the Vicissitudes of Individuation*. New York: International Universities Press.

Malan, D. H. (1976), *The Frontier of Brief Psychotherapy*. New York: Plenum.

Mandler, G., & Kaplan, W. K. (1956), Subjective evaluation and reinforcement of a verbal stimulus. *Science*, 124:582-583.

Mann, J. (1973), *Time-Limited Psychotherapy*. Cambridge, Mass.: Harvard University Press.

Marmor, J. (1962), Psychoanalytic therapy as an educational process. In: *Science and Psychoanalysis*, Vol. V, ed. J. Masserman. New York: Grune & Stratton, pp. 286-299.

———(1964), Psychoanalytic therapy and theories of learning. In: *Science and Psychoanalysis*, Vol. VII, ed. J. Masserman. New York: Grune & Stratton, pp. 265-279.

Masserman, J. (1980), *Principles and Practice of Biodynamic Psychiatry*. New York: Thieme-Stratton.

Miller, N. E., & Dollard, J. C. (1941), *Social Learning and Imitation*. New Haven: Yale University Press.

Rado, S. (1956), Recent advances in psychoanalytic therapy. In: *Psychoanalysis of Behavior*. New York: Grune & Stratton.

Salzman, L. (1976), The will to change. In: *What Makes Behavior Change Possible?*, ed. A. Burton. New York: Brunner/Mazel, pp. 13-33.

Sifneos, P. E. (1972), *Short-Term Psychotherapy and Emotional Crisis*. Cambridge, Mass.: Harvard University Press.

Strachey, J. (1934), The nature of the therapeutic action of psychoanalysis. *Int. J. Psycho-Anal.*,

15:127-159.

Strupp, H. (1976), The nature of the therapeutic influence and its basic ingredients. In: *What Makes Behavior Change Possible?*, ed. A. Burton. New York: Brunner/Mazel, pp. 96-112.

Sullivan, H. S. (1953), *Interpersonal Theory of Psychiatry*. New York: Norton.

Notes

1 An earlier version of this chapter was presented at the Annual Meeting of the American Academy of Psychoanalysis, Atlanta, Georgia, May 1978, and appeared in the *Journal of the American Academy of Psychoanalysis*, 7:345-357, New York: Wiley, 1979.