Ferenczi's Turn in Psychoanalysis

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One night last winter, after having purchased a guidebook that day to eastern Europe, I was planning my trip to Prague and the Ferenczi conference in Budapest. Having seen the movie, *The Music Box*, with many scenes of Budapest about a year before, images from the film came to mind as I perused the travel guide. The images from the film were the only pictures of Budapest I had ever seen. The movie starred Jessica Lange. Not surprisingly, Jessica Lange was in a dream of mine that night. (I won’t discuss what dissociated and/or wished-for aspect of myself she might represent.) There was also music playing that I didn’t quite recognize. A musician friend happened to call me the next morning, and I hummed the tune to her. “Dvorak’s *New World Symphony*,” she said. The music in *The New World Symphony*, a beautiful blend of classical themes with Native American and African spirituals, seems an appropriate metaphor for psychotherapy integration—a blend of Freud’s now “classical” technique with some of Ferenczi’s innovations and strands from non-European traditions.

At the conclusion of *The Development of Psycho-Analysis* Ferenczi and Rank declare:

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If we have attempted in the foregoing pages, venturing from the present direct facts, to forecast the prospects of psychoanalysis, this seems to us more than an idle play of phantasy. . . . The most important advance in psychoanalysis consists finally in a great increase of consciousness, or expressed according to our metapsychology, in raising the instinctive unconscious mental content to the level of pre-conscious thinking. This, however, from our point of view, means such an important step in the development of mankind, that it may actually be regarded as a biologic advance, and indeed as one which for the first time takes place under a kind of self-control. Under the influence of this increase in consciousness the physician, who has developed from the medicine man, sorcerer, charlatan, and magic healer, and who at his best often remains somewhat an artist, will develop increasing knowledge of mental mechanisms, and in this sense, prove the saying that medicine is the oldest art and the youngest science. (1923, 67–68)

Psychoanalysis and psychotherapy are at the interface between art and science. Although psychoanalysis in this century has until recently been largely removed from the developments in scientific psychology and psychiatry, the return of scientific psychology to the study of conscious and unconscious processes after prolonged neglect has rejuvenated the integration of psychoanalysis with other forms of psychotherapy, some of which, such as behavior therapy, are based on research findings in psychology.

When should clinicians engage in techniques that are not traditionally psychoanalytic? This question, grappled with by Ferenczi in his spirit of experimentation, is increasingly coming to the fore for psychoanalysts today. And what differentiates contemporary psychoanalysis from other forms of psychotherapy?

With academic psychology having at last fully embraced nonconscious processes after they were effectively banned by William James a century ago, the features that make psychoanalytic therapy and psychoanalysis distinct from other forms of therapy are becoming blurred. Cognitive-behavioral therapists now tell patients to lie down and report whatever comes into their stream of consciousness; they also examine what is going on in the relationship between the patient and the therapist. Many psychoanalysts, on the other hand, no longer believe in the centrality of the Oedipus complex and work with patients who are for a very long time too anxious to discuss the relationship with the analyst. For those of us who were trained as clinical psychologists before seeking analytic training and who
felt we gained a lot from the encounter groups and T-groups of the 1960s and early '70s, the question often comes to mind, “Should I try such and such a technique?” especially when we are not seeing a patient in a formal psychoanalysis.

In this chapter I propose to raise some questions regarding the integration of three types of techniques introduced by Ferenczi into psychoanalysis and psychoanalytic therapy: (1) relaxation; (2) the active techniques of suggestion and advice-giving; and (3) what I shall call active fantasy or suggested fantasy, derived from Ferenczi's idea of forced fantasy and from the imaging techniques in cognitive, experiential, Gestalt, and encounter therapies. I shall raise these questions in the tradition of Ferenczi himself, who always kept in mind the importance of unconscious and transferential processes and strove to overcome inhibitions blocking conscious awareness.

Some case examples will clarify the issues surrounding the decision whether or not to use a guided relaxation technique with a patient. Sue came to consult me initially seeking short-term therapy. She was an administrative assistant in an office and had been recommended to me as a “good patient.” I found out from her that she had been hospitalized once for a suicide attempt, although she refused to discuss the matter further. She was suffering from panic attacks on the subway that were so bad that she had to get off several times on the way to work; they also prevented her from going to sleep. I agreed to work with her on a short-term basis. I taught her breathing and imaging techniques so that she could stay on the subway. With some success in allaying this anxiety, she then began to discuss her very serious problems at work and in a relationship.

Two other patients with job and relationship problems also mentioned that they had panic attacks at night. One was in analysis; the other was not, though she had therapy lying down on the couch and eventually began analysis. I addressed their panic only with intellectual inquiry. The panic attacks subsided, apparently as a result of the patients' diminished fear of the experiences and the safety of the analytic situation.

When should therapists use such direct relaxation techniques? A discussion of the history of active techniques in psychoanalysis provides a useful background to the consideration of specific uses of relaxation, suggestion, and suggested fantasy.
Psychoanalysts have traditionally been opposed to any sort of active techniques. Kenneth Frank (1992) has articulated at least five major types of arguments against them: (1) analysis should focus on the therapeutic relationship as the central agency of change; (2) active techniques violate the requirement of analytic neutrality or abstinence; (3) an awareness of the mutative impact of interpretations has made analysts wary of techniques involving suggestion and manipulation; (4) all activity is associated with resistance in psychoanalysis—denial, acting out, and other defenses opposing introspection, verbalization, and insight; and (5) the theoretical formulations about personality on which these techniques are based are too limited and fail to recognize deep structure, conflict, and unconscious motivational forces.

Recently Frank (1993) has described the disparate views held by analysts regarding the goal of psychoanalysis. For those who see the goal as understanding, active techniques may seem inappropriate. Few analysts, however, would limit the goal to understanding. Most also consider the working through and resolving of inhibitions a desideratum, and many, like Ferenczi, strive for the reduction of anxiety and the freeing of creative possibilities for problem-solving. By employing behavioral and cognitive therapies designed to reduce anxiety, the possibilities for integrating techniques drawn from these therapies are enhanced.

What has been the experience of integrating such techniques into analysis since Ferenczi? Freud, of course, frowned on Ferenczi’s use of relaxation techniques, and the psychoanalytic community as a whole strongly opposed Franz Alexander and Thomas French’s proposal that the therapist “at the right moment, should encourage the patient (or even require him) to do those things which he avoided in the past, to experiment in that activity in which he had failed before” (1946, 41).

Harry Stack Sullivan distinguished a “prescription of action” from ordinary advice-giving. Although he believed it to be harmful to give advice except in unusual situations, he did recommend that an interviewer indicate “a course of events in which the interviewee might engage and which, in the interviewer’s opinion, in view of the data accumulated, would improve his chance of success and satisfaction in life” (1954, 212). For Sullivan, advice would simply reflect the therapist’s personal values or hunches. To
indicate to the patient, on the other hand, the fairly predictable consequences of courses of action was not only acceptable, but the therapist's responsibility (Wachtel 1977, 68).

Paul Wachtel has been the leading advocate of the integration of nonpsychoanalytic—and specifically behavioral—techniques into psychoanalysis. With Marvin Goldfried, a cognitive-behaviorist, and others, he organized the Society for the Exploration of Psychotherapy Integration, which has been growing internationally. Wachtel has argued explicitly that patients must be encouraged to approach anxiety-provoking situations after psychoanalytic exploration has determined what they are.

Frank has written recently about integrating nonpsychoanalytic techniques into psychoanalysis and psychoanalytic therapy. He has described a case in which he introduced cognitive-behavioral anger-control techniques and diary-keeping into the treatment of an abusive mother (1992) and explored the use of relaxation techniques with a patient experiencing panic attacks (1993). Frank has argued that the movement from a one-person blank screen model of psychoanalysis to a two-person interactional perspective makes active techniques more palatable and comprehensible theoretically.

Wachtel (1993), in a commentary on Frank, points out that the patient's view of the analyst's behavior—whether that be silence, interpretation, or an active technique—must be explored and analyzed. Silence and interpretations are behaviors as much as is the direct proposal of a means of coping.

Frank (1991, 742) has formulated seven guidelines to aid in integrating active techniques into psychoanalytic treatment: (1) they must be used in a way that advances psychoanalytic inquiry; (2) their use must avoid enactments and be based on thoughtful consideration of each patient's overall therapeutic needs; (3) the analyst's possible countertransferential motivations must be continually monitored; (4) the advantages and disadvantages of choosing one approach over another always need to be weighed; (5) the analyst must seek to avoid taking away initiative and control from the patient; (6) the analyst must not become overly invested in behavioral change; and (7) active techniques may need to be modified for use in psychoanalytic therapy and administered in small doses to investigate thoroughly the patient's reactions.
My own formulation as to when to use active techniques is somewhat different. Having been trained as a clinical psychologist and having taught theories and techniques of therapy (including nonanalytic ones) before seeking training in a psychoanalytic institute, I feel free to use whatever techniques seem most appropriate, whether or not I am doing analysis. As I think back over the patients with whom I have used active techniques, they are those with the most severe deficits and who functioned most poorly, such as patients who had been hospitalized before I worked with them. Upon examining the two cases Frank has recently discussed, I note that the patient to whom I taught anger-control techniques had an apparently borderline mother who was sometimes physically abusive, and a submissive, ineffectual father. The cognitive-behavioral techniques were employed in the fourth year of treatment. The patient with the panic attacks was someone with a history of hurting herself by striking her face with a hairbrush until she caused abrasions and bleeding. Both patients not only experienced severe anxiety, but at times acted in physically destructive ways.

In psychoanalysis or psychoanalytic therapy, I am unlikely to use techniques beyond relaxation, implicit suggestion, and suggested fantasy. This is because my psychoanalytic patients are already functioning without the sorts of deficits that might warrant more active techniques. I would like to turn now to a further discussion of the innovative techniques I have found useful in analytic work.

*Relaxation*

"Analysis begins with relaxation," Ferenczi wrote in his *Clinical Diary* (1985, 49). I would go further and say that analysis begins, continues, and ends with relaxation. But relaxation is not an end in itself. Through the relaxation of mental blocks, exciting new connections are made. Although some analysts (perhaps a small group) do not believe it is important whether a patient is on the couch or not, and some believe it is demeaning to the patient, I am a proponent of the use of the couch for all patients who will be more relaxed lying down. Recent research has shown that brain waves are different when patients in psychoanalysis are sitting up and lying down,
with supine patients emitting more theta waves. Along with Ferenczi, I see the goal of psychoanalysis to be the freeing of inhibitions to conscious awareness, and this freeing occurs more readily when people are lying down. Robert Stigold, a neurobiologist who works in Hobson's dream laboratory, points out that the brain is physiologically able to make more connections when people are relaxed.¹

In recent papers (Curtis 1992, 1993) I have presented a model of conscious and unconscious processes somewhat akin to Freud's topographical model and argued that dynamic and nondynamic nonconscious experiences are selectively attended to and recalled by the same processes. This model incorporates the data of contemporary cognitive scientific research and philosophical views of the mind. I cannot elaborate that model here, but suffice it to say that I agree with Ferenczi that "the unpleasure that arises when certain connections are made is avoided by the giving up of these connections" (1985, 38). "Relaxation ... requires unifying the personality completely and allowing all perceptions to register on the self in an unfragmented way: that is, actually a kind of re-experiencing" (54). Psychoanalysis is a process by which connections can be made not only with conscious awareness but among other representations of which one may not be fully aware, such as nonconscious representations of self and others. (Meditation is another process by which one attempts to allow all experiences into awareness.)

Relaxation is central to all psychotherapy. The patient must trust the therapist and feel reasonably safe for therapy to occur. Just as behavioral treatments frequently involve desensitization to feared stimuli, psychoanalysis operates in a similar fashion, with the patient discussing increasingly anxiety-provoking processes in a safe place in the presence of a trusted analyst. Ferenczi introduced his relaxation technique after finding in several cases that his exaggerated frustration technique was not helping, especially when patients came to him after previous failed analyses. Although Ferenczi initially equated relaxation with indulgence, from reading his Clinical Diary and other papers as well as reports of others about him, I have gained a sense of the deep trust and sense of safety patients must have felt with him, which seems to have come more from his personal way of being than from his technique per se. For patients to have entered a trance state without any
specific instructions, there must have been enormous trust. Ferenczi, in his use of relaxation, did not rely solely on the safety created in the analytic situation. He instructed his patients in the relaxation of the posture of their muscles (1930, 115).

Behavioral therapists use relaxation techniques as a way of applying learning theory to the treatment of anxiety. Patients are taught breathing techniques to reduce states of panic and to remain calm in desensitization procedures as they are exposed to increasingly anxiety-provoking stimuli. I maintain (1992) that behavioral psychologists have been concerned with explicit or self-reported anxiety whereas psychoanalysts have been concerned largely with implicit or unconscious anxiety. Effective treatments for both implicit and explicit anxiety give patients ways of relaxing and approaching feared experiences.

Sullivan's (1954, 104) idea that as therapists we should strive for an optimal level of anxiety makes sense only if we can be sure that patients are feeling secure that the relationship will not be terminated and that they will not be hurt by undergoing increasingly anxiety-provoking experiences. As therapists we can do this best when our patients feel safe and relaxed.

**Suggestion**

When I was cleaning up my library as I started to write this chapter—cleaning is something I rarely feel like doing except when I'm anxious about doing something else—I came across an article by Irwin Hoffman (1993) describing a scene from a TV show called “Sessions” starring an analyst or therapist played by Elliot Gould. The patient was thirty-five to forty years old and quite estranged from his father, who was likely scared due to his wife's illness and his own feelings of helplessness. The therapist said to the patient regarding the father, “Maybe he needs someone to talk to.” The patient asked, “You mean a shrink-type person like you?” The therapist responded, “Actually, I was thinking of a son-type person like you.” The patient then spoke to his father and they were reconciled. Hoffman argues in favor of this use of suggestion, in light of the long-term consequences for the patient if the father had died without the reconciliation.
Ferenczi, of course, used suggestion. Even routine questions such as, "What keeps you from doing such and such?" implicitly contain suggestions. Most analysts also offer explicit advice under certain circumstances—for example, when the situation is life- or treatment-threatening, perhaps after traditional analytic exploration has taken place. The situation described by Hoffman is an intriguing one. Even if the question were phrased, "What keeps you from talking to your Dad?" the possibility of a behavior has been suggested to the patient. It seems to be a matter of a commonsense weighing of costs and benefits. The cost of making a suggestion does not seem to be as great as the cost of a parent dying without an experience of a renewed relationship. In group psychotherapy lasting fifteen sessions, I have watched members successfully suggest on many occasions that another member reinitiate contact with a family member or friend; there is often profound joy and gratitude for the encouragement. I have watched group members alter phobias of driving cars that have existed for many years. Although reliance on the analyst for suggestions is something we certainly don't want, nor would we want suggestion to usurp analysis, there are occasions when the consequences are so enormous that it seems irresponsible not at least to inquire why the patient would not consider a particular action.

Ferenczi defines his active technique as "requesting the patient upon occasion, in addition to free association, to act or behave in a certain way in the hope of gaining thereby . . . mental material that lay buried in the unconscious" (1926, 37). He tells us that "experience later taught me that one should never order or forbid any changes of behavior, but at most advise them, and that one should always be ready to withdraw one's advice if it turned out to be obstructive to the analysis or provocative of resistance" (1928, 96). Freud (1918, 166) had maintained that phobic patients must eventually be induced to approach the anxiety-provoking experience, so an exhortation to engage in an action was not a deviation from Freud's technique.

Ferenczi eventually concluded that, if we can wait long enough, "the patient will himself sooner or later come up with the question whether he should risk some effort, for example to defy a phobic avoidance" (1928, 97). Of course, we may not have time to be so patient. Active techniques,
for Ferenczi and Rank (1923), were designed to aid in the overcoming of resistance. But Ferenczi also wrote later that “analysis is preparation for suggestion” (1932, 270).

Freud, as is well known, held that “the pure gold of analysis might be freely alloyed with the copper of direct suggestion” and that the hypnotic means of influence “might find a place in [analysis] again” (1918, 168). The initial distrust of suggestion in psychoanalysis stemmed from the belief that its benefits were only temporary and that the symptoms would recur if the analyst did not help the patient to overcome the dissociations that had prevented him or her from arriving at such results independently (Ferenczi 1928).

Experiential, Gestalt, and Encounter Techniques

I shall now discuss Ferenczi’s use of “forced fantasy” and the integration of some techniques from the experiential, Gestalt, and encounter traditions with psychoanalysis.

Ferenczi reports that when he attempted “actually to transport [himself] with the patient into that period of the past,” Freud reproached him for it (1985, 24). He adds that, absent such an experience, the analysis will remain on an intellectual level. He points out that the analyst too must be able to relax, but not so far as to enter an actual trance state. Given the importance of fantasy and play to psychoanalytic theory, it is surprising that relaxation should not be used more often. Clearly, the theoretical hostility to acting out a fantasy in the treatment situation by role-playing derives from the view that it is more beneficial to talk about an experience than to repeat it. It is unclear, however, why this premise would extend to an inhibition regarding acting out in fantasy the scenarios of dreams, memories, and desired or feared events. If one of the goals of psychoanalysis is to free people from inhibitions regarding their thoughts and feelings, moreover, it would seem to be commendable for analysts to free themselves.

Let me describe briefly the technique used by Alvin Mahrer, a leading experiential psychotherapist. In each session, both the patient and the therapist close their eyes, and the patient is requested to report on a feeling she or he is experiencing. The patient is urged to experience this feeling
more intensely, then is asked about a time recently when she or he felt this way, and then about an analogous time in the past; the session concludes with the patient being asked to imagine some ways that current situations might be handled differently. Mahrer and the patient do precisely what Freud reproached Ferenczi for doing, i.e., they transport themselves into a given period of the past. When a patient is describing the past in an intellectual fashion, happy though I am at times to get the history, I find myself saying, "Be there now."

Ferenczi advocated a technique he called "dream interpretation during relaxation" (1985, 67). With it he attempted to take the patient back into a dream during the analytic session, with the aid of conscious associative material. To do this, he tells us, a certain state of drowsiness and relaxation is necessary. One requests the patients to "penetrate deeper into the feeling, seeing, and experiencing of each detail, whereupon they produce small details and data about the dream-fragment, which by all appearances are derived from reality. This kind of submergence into a dream leads, in most cases, to a cathartic exacerbation of the symptoms, which then provide us with an opportunity to get closer to reality" (67).

A perhaps similar technique taken from Gestalt therapy that I have frequently found useful is to tell the patient to "become" each of the different people and objects in a dream or fantasy. For example, if a patient tells me that she "has her wall up," I tell her to "become" the wall and say "I am the wall," and to report what she does and feels. Having gotten thirty-five undergraduate students per semester to engage in this activity in front of their classmates (with the assurance that not participating would not affect their grade), I know that it can be done without much resistance. If patients are hesitant, their fears of even imagining something can, of course, be explored.

The technique of calmly imagining a hierarchy of anxiety-provoking stimuli was developed by behaviorists and is used frequently now by cognitive therapists. A different technique advocated by Ben Feather and John Rhoads (1972) is to ask the patient to imagine his or her worst fears. For example, one patient who had a driving phobia for ten years and feared he would hit pedestrians was told to imagine deliberately running over someone. After he imagined such scenes with increasing enjoyment, his anxiety
diminished and in two weeks he was able to drive across the state. Similarly, another patient experienced a writing phobia that was related to revealing secret information. After the patient was asked to imagine deliberately disclosing all the secrets of his company by emptying all the file cabinets into the street, the phobia dissolved. This patient had spent years in psychoanalysis without improvement and may even have become worse. I don't see that the suggestion to imagine events and feelings is inconsistent with psychoanalytic principles.

In using the techniques of imagining feared experiences, Gordon Paul (1966), like Ferenczi, believes that it is important for patients to imagine the situation as though they were in it, meaning that they should not see themselves in the picture, for then they are viewing it as outside themselves. Instead they are encouraged to see the things around them as if they were there. If patients are reluctant to imagine an experience in fantasy, the therapist may need to point out the difference between reality and fantasy. It is crucial to try to distinguish between the consequences of wishes and of overt behaviors. Implicit in this technique is the assumption that it is beneficial for patients to be able to experience all of their potential feelings and impulses so that they do not need to keep any experiences out of awareness.

I shall now give a case example in which I went beyond the use of imagined wishes or fears to a technique I would label "suggested fantasy." The patient was a twenty-nine-year-old aspiring artist who had been seen previously for five years (usually twice a week) by another therapist, sometimes individually and sometimes in a group. The patient viewed this therapy as helping her to be able to get involved in a relationship with an available, nice man. She saw me twice a week and chiefly discussed the frustrations in her career. Occasionally she mentioned her plans to get married to the man, with whom she was living, and her fears that she might end up like her mother, who had not had sex with her stepfather for the past ten years. She had experienced sexual difficulties with her fiancé for the past year and rarely had sex, which she attributed to their busy schedules and problems with her back, although during the first six months of their relationship she had experienced no particular problems. She described her fascination with fairy tales beginning in childhood and her
desire to have a prince save her and to live happily ever after. I wondered whether she might be getting married to have someone support her.

The patient had been sexually abused when she was thirteen by her stepfather's touching her vagina while telling her that he just wanted to examine her. The patient reported that she had been reading many "trashy" novels at that age and was having fantasies about sex with older men. The previous year she had told her mother that she was a twenty-four-year-old in a twelve-year-old body. She did not and had never masturbated. She described her stepfather as quite good-looking and a man to whom many women seemed attracted. She could remember nothing about her feelings regarding the incident, however, except that she felt angry, but that her stepfather must know best. When she told her mother, she responded by saying that the stepfather must have been just having fun and she was sure he hadn't meant anything.

While seeing the patient twice a week for eight months, I usually felt like another appointment during her week of physical therapy, art, and exercise classes. She could spend two whole sessions discussing a mole on her face or crying profusely because her wedding dress was not pretty enough. I felt frustrated by her plans to get married in spite of her sexual difficulties and her fears that she would end up like her mother. But these were apparently outweighed by her fears of being left unprotected in life by a man. Although the patient had no memory of her early childhood and had not learned that her stepfather was not her natural father until she found photographs in the attic, it emerged that her biological father had died when she was three years old, and that her mother's mother had died several weeks before, thus leaving the mother of two young girls very depressed.

Since she was determined to get married, I was relieved when she again decided to discuss her sexual difficulties. She felt extremely uncomfortable with any type of foreplay. When I asked about her feelings toward her stepfather, we got no further than before, so I invited her to imagine the event as if she were there now and to describe all the details. She imagined the scene, but said nothing she hadn't said before. I then encouraged her to imagine finding some pleasure in the event. Although she insisted that it
was not at all pleasurable and that imagining it in that way would hurt her mother, she was able to do so. The following session she came in excitedly and told me that she had experienced pleasure in sexual foreplay with her fiancé, and so far she has not reported further difficulties.

Arnold Rachman (1988, 1991) has taken the use of suggested fantasies and psychodrama one step further in his mode of humanistic analysis. He leads patients through three phases: (1) an empathic phase; (2) an analytic phase; and (3) an action phase. Like many of us who believe strongly in the value of group therapy, Rachman thinks that patients benefit from moving from an intense individual experience with the analyst to a setting that elicits personality change with significant others in the “group family.” In group work Rachman uses many active techniques associated with the encounter group movement, such as trust exercises and psychodrama. In his description of his work with the patient he has called “Oedipus from Brooklyn” (1988), Rachman reports that he had him not only enact scenes that might prove catalytic, but even wear costumes and masks and set the stage with candles, incense, etc. Rachman also employs what he calls hypnotic regression by inducing a relaxed state through the use of music, a dark room, and a glowing light.

Ferenczi wrote not only about countertransference, but also about counterresistance. As analysts, we are frequently the ones who are resistant to change. Even when a strategy repeatedly fails to work, we remain wedded to it, afraid to stray from the conventions that have been passed down through our own analyses and sanctioned by the analytic community. Ferenczi, in the spirit of experimentation, tried out many techniques and later described how they failed. We also know of the positive benefits to be derived from his successful techniques. If our patients sense that we are unwilling to engage in new behaviors, how can we expect them to make even bigger changes? If creative living is a goal of psychoanalysis, our techniques must involve an interplay between freedom and discipline.

It was a powerful experience in my own analysis when my analyst asked to enter my fantasy world. After telling him of a preanalytic dream about a ferris wheel in Vienna, he asked, “How would it be if I came on the ferris wheel with you?” In response I wrote:
What a technique-y thing to say.
Something he learned at the psychoanalytic institute
Or from Harold Searles, I bet.
"How would it be if I were to ride on the ferris wheel with you?" he said.
That ferris wheel in Vienna I dreamed about years ago
From which you can see out for miles around
That cycle of creation and destruction
That wheel of life
Attached in the center to a mountain
No place to get on or off—
I don't know how you end up there.
"Pleasant, scary, exciting,"
I thought at first—
Then I didn't want him getting that close to me and disappearing
After the ride I paid for was over.
And how would I not touch him
On a ferris wheel ride?
But then, it would be exhilarating
No one had ever asked to enter my inner world before—
My world of dreams—
So, I said, "Maybe, in September."
I can't tell exactly where reality ends and fantasy begins.
But I think someone is coming along with me.

Guidelines for Using Active Techniques

We would never insist that our children do something they are not capable
of doing without first showing them how. Analogously, many of our
patients have severe developmental deficits, and to expect them to work
analytically all the time would be unrealistic and set them up to fail.
John Gedo (1988) and Michael Basch (1988) have recently argued for
the introduction of educative techniques into analysis. My guidelines for
employing active techniques are the following:

1. Nonpsychoanalytically derived techniques can help to reduce severe
symptoms in many patients. If they are tactfully employed, without further
probing of the meanings of experiences, patients frequently find therapy
useful and are then eager to present other problems. In time, they may
become amenable to a psychoanalytic approach. When these techniques
are not successful, therapists, regardless of orientation, must explore more fully the meaning of events.

2. Nonpsychoanalytically derived techniques are useful in attempts to induce patients to recollect, reexperience, and emotionally understand events in their lives and the meanings they give them, and in freeing their inhibitions to awareness.

3. Nonpsychoanalytic techniques should be used when the long-term benefits for the patient outweigh the costs of not using them.

4. The therapist's comfort in using nontraditional psychoanalytic techniques will depend upon the value he or she places on simply pointing out a repetition of a pattern in the transference as opposed to freeing inhibitions against trying out new experiences.

Conclusions

The "increase in consciousness" that takes place in psychoanalysis is, as Ferenczi and Rank argue, "more than an idle play of phantasy" (1923, 67). Psychoanalysis is conducted in the interstices between actual events and the meanings people make of them, in the playground of the mind between reality and fantasy. It presupposes relaxation and may include encouragement that the patient shed his or her inhibitions to awareness, indulge in fantasies, and decide which ones he or she will attempt to make come true. When both patients and analysts are open to as many connections as our minds are capable of making, to all of our possibilities and potentialities, the psyche passes through that mysterious portal of the human spirit from passion to being that we call creation. Thus, strands from both old and new traditions can come into awareness and compose in both our professional and personal relationships our own psychoanalytic symphonies for a new world.

NOTES

REFERENCES


