Psychoanalytic Perspectives

Psychoanalysis and the 21st Century: A Critique and a Vision

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To cite this article: Kenneth A. Frank PhD (2013) Psychoanalysis and the 21st Century: A Critique and a Vision, Psychoanalytic Perspectives, 10:2, 300-334, DOI: 10.1080/1551806X.2013.827077

To link to this article: http://dx.doi.org/10.1080/1551806X.2013.827077

Published online: 07 Oct 2013.
PSYCHOANALYSIS AND THE 21ST CENTURY: A CRITIQUE AND A VISION

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The author traces a current crisis in psychoanalysis to its inwardness and insularity, which have left it insufficiently progressive in relation to cultural shifts. We must more expansively open ourselves to contemporary cultural influences and connect inclusively with wide-ranging therapeutic approaches and intercultural disciplines—the arts, humanities, and sciences. This outward-leaning orientation opens psychoanalysis to interdisciplinarity, broadens its methodological integration, and promotes its growth by positioning it in the current of progress of a variety of other disciplines and psychotherapeutic schools.

Keywords: psychoanalysis, psychotherapy, integration, vision, critique, crisis.

Most psychoanalysts have come to recognize that nothing short of a multiplicity of perspectives and methods is necessary in a discipline with a subject matter as complex and subtle as psychoanalysis. The postmodern zeitgeist supports such multiplicity by acknowledging the legitimacy and desirability of scholarship that accepts numerous interpretations of experience and encourages the advancement of knowledge through ever-widening intellectual perspectives. Yet the fragmentation of knowledge continues as an artifact of traditional scholarship, the natural limitations of the human intellect, and additional cultural, political, and economic factors.

A result in psychoanalysis is a counterproductive insularity that has resulted in a contextually expectable fragmentation of accumulated knowledge. Far more desirable is an interdisciplinary approach that offers a way of looking beyond specific systems of inquiry governed by artificially separate and delimited fields.

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Psychoanalysis and the 21st Century: A Critique and a Vision

Interdisciplinarity assumes that the fragmentation and insularity we observe among forms of psychoanalysis and other approaches to psychotherapy are inherent in the constructed nature of knowledge of the therapeutic process itself. Interdisciplinarity is inherently relational; through it we can make strides toward overcoming the problematic separation between knowledge areas that has slowed psychoanalytic and psychotherapeutic progress. The proverbial blind men with the elephant must confer with one another if they are to arrive at a fuller understanding of the elephant.

Inwardness and fragmentation are prominent among the factors that have brought psychoanalysis to a crisis it now faces. Nonanalytic approaches have been expanding and gaining mounting support outside the major urban centers that serve as bastions of psychoanalysis. The “old guard”—the most conservative among us who enshrine “pure” psychoanalysis and eschew and marginalize other modalities—must reexamine their positions for remaining focused narrowly and rejecting innovative developments risks further marginalizing psychoanalysis and courting its potential irrelevance and even obsolescence. Constructively, we must: (a) reverse our historical insularity through interdisciplinarity; (b) more fully acknowledge and integrate the role of context, on many levels; (c) promote ways the “hybrid” nature of psychoanalysis can be tapped to advance rather than polarize us and stultify analytic progress; (d) recognize the coherence of diverse forms of knowledge and the “consilience” among them (Wilson, 1998); and (e) recognize and implement the synergies of inter-modality integration in clinical practice.

Psychoanalysis in Crisis

Those of us who are deeply committed to psychoanalysis find these trying times. As we attempt to educate the lay public about the many important changes in analytic treatment that have occurred with the relational revolution, health insurance carriers attack psychodynamic therapy by aggressively promoting shortened treatment to advance their cost-containment priorities. Intrusively, they regularly pressure therapists and subscribers to shorten therapy, often bringing about abortive treatment endings. In addition, recent data show that ten percent of Americans—a
growing number that is estimated to have doubled in a decade (Olfsom & Marcus, 2009)—take antidepressants, the most commonly prescribed class of all drugs. Although research findings show that in many, perhaps most, instances combining pharmacotherapy with “talk” therapy can be most effective (Cuijpers, van Straten, Warmerdam, & Andersson, 2009), the number of patients taking medication alone nevertheless continues to grow faster than that of those in combined therapy.

Problematically, not only health insurers but also the National Institute of Mental Health and American Psychological Association have weakened their support of analytic therapy. Their agendas favor readily researchable problems and training opportunities that concentrate on short-term therapies with objectifiable, quantifiable, and often narrowly defined symptom-focused goals as outcome criteria. Hence, they end up promoting manualized, or so-called evidence-based treatments to the detriment of longer-term therapies.¹,² Those approaches may be suited to the discrete symptoms and syndromes listed in the medicalized DSM-IV and DSM-V, which insurers insist we use for diagnostic purposes, but which is more in line with analysts’ goals from the 1960s than today. The stunted therapies these insurers and governmental and professional institutions advocate, while ostensibly progressive and sometimes practicable, are unsuitable for a great many patients, especially the many who come to us seeking help with “transdiagnostic” issues, such as a sense that their lives are unfulfilling. Another fact that “evidence-based” views fail to recognize relates to research findings that appear to demonstrate—consistently and across modalities—that the most useful therapy of all occurs in a strong, safe, intimate relationship (Norcross, 2011). Truly helpful relationships typically develop gradually over time—an impossibility in standardized “quick fix” therapies. The latter also discourage needed forms of clinical creativity and innovation.

Those who repudiate psychoanalysis and promote evidence-based and manualized treatments also overlook the many variables

¹An analyst colleague half-jokingly said, “I favor evidence-based psychotherapy—providing that I get to choose the evidence.”

²A study by Shedler (2010) published by the American Psychological Association describes research supporting the efficacy of psychodynamic therapy, and challenges claims for the superiority of other “empirically supported” or “evidence-based” therapies.
that analysts, like patients, do not and cannot anticipate, control, or meaningfully measure, including the significant yet unforeseeable personality change that results from nonlinear, emergent systems. I fail to see how informed, experienced psychoanalysts who have helped to bring about profound psychoanalytic change can, acting with professionalism, yield to pressures to perform in the diminished manner proponents of these more limited approaches advocate.

**Past, Present, and Future**

Lewis Aron (in Safran, 2009) responded to some of the concerns of contemporary psychoanalysts when he commented on an article in *The New York Times Book Review* by Daphne Merkin (2004). The review had the barbed—and falsely dichotomous—title “Psychoanalysis: Is It Science or Is It Toast?” Aron explained, somewhat optimistically, that:

> Whatever managed care says, and whatever drugs are prescribed, and whatever the research findings, people still want to be listened to in depth and always will. That’s why there will always be patients who want and need an analytic approach and why there will always be therapists who need to learn it (Aron, as cited in Safran, 2009, p. 116).

Aron has made outstanding contributions to psychoanalysis, and as far as his assertion here goes, few analysts would disagree. He does indeed state one of many reasons psychoanalysis offers something uniquely valuable and necessary. It has been said that being known is second only to being known and loved.

But past practice alone offers insufficient justification for that of the present or future. I believe Aron would agree with my assertion here—that we must somehow reconcile the recursive nature of theory-bound praxis with the conflicting reality that culture and context are dynamic and perpetually changing. When we unquestioningly accept as gospel and apply the lens of any one particular approach, rather than that of another or others, we introduce a bias and self-fulfilling prophecies; we find what we are looking for, what we expect to see, although other, superior lenses may exist. To the extent that we justify our practices using those of the past, or uncritically embrace the present, we...
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remain conservatively locked in a closed system, having little or no opportunity to discover another more progressive way, or ways, of understanding that might better serve us and those who seek our help. An insufficient number of analysts have responded openly to a shifting context involving rapidly expanding knowledge, new developments in psychology and psychotherapy, and the shifting conditions and needs of the patient population we serve. We must push the traditional psychoanalytic envelope.

In this paper, I offer a critique of contemporary psychoanalysis. Then, adding to Aron’s observation, I will outline an approach based on my critique. Although what I am proposing is an emendation of traditional analytic therapy, and a direction to follow, what I propose neither sounds the death knell for psychoanalysis nor leads to an appeal for short-term or evidence-based analytic treatment. Both are far from what I have in mind, although, ironically, I can see aspects of analytic practice evolving favorably as the result of some of the many threats we face. For instance, some analysts, such as Renik (2006) and Hirsch (2009), constructively have emphasized the importance of greater accountability on the part of analysts. Beyond this, I propose a forward-looking perspective that takes new developments into account and is more open and responsive to the current intellectual and cultural climate than traditional psychoanalysis has been.

First, I will trace our history both to delineate our progress and to highlight several limiting trends in conventional psychoanalysis. I will argue, especially, that our insularity has been a serious problem that requires remediation. Then I will turn to some practical implications and my vision for the future.

Many favorable, even dramatic changes have occurred in psychoanalysis over the past 50 years. A strong influence for change developed during the 1950s and 60s from outside the American psychoanalytic mainstream—the interpersonal tradition (Fromm, Fromm-Reichman, Horney, Sullivan, and Thompson); object-relations theory from Klein and the British independent group (including Fairbairn, Guntrip, and Winnicott); and later

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3The reader familiar with the broader literature on psychotherapy integration, and my own earlier papers in the area, may regard this paper as an extension and update encompassing new developments and reframing that project for a more hospitable contemporary climate.
from Kohut’s self psychology. These influences contributed to a “humanization” of mainstream American psychoanalysis, beginning with the “alliance” concepts of Greenson, Stone, and Zetzel (Greenson, 1965), and reaching maturity in the recognition of the importance of the analyst as a “new object,” as earlier introduced by Loewald (1960). The work of Greenberg and Mitchell (1983) represented a major turning point. They identified and called attention to the importance of these developments as a paradigm shift—a profound change in the basic assumptions underlying psychoanalysis—from what they called the drive/structure model and toward a model built on relational/structure.

Important empirical support came from the findings of the multiyear Menninger Psychotherapy Research Project, begun in 1954 and in some cases lasting for 30 years, documenting relationship factors such as therapists’ support as playing a crucial role in therapeutic action (Wallerstein, 1989). As a project designed and conducted by a number of high-profile psychoanalytic leaders and solid researchers, the findings dissolved the boundary lines, formerly clearly drawn, between formal psychoanalysis and analytic or supportive therapy. That blurring of boundaries fostered a loosening of tradition’s grip and established greater latitude for innovation in clinical thinking and practice. Mitchell’s (1988) merging of interpersonal psychoanalysis, self psychology, and object-relations theory into a relational integration was followed by further integrations including intersubjective insights (Atwood & Stolorow, 1984; Benjamin, 1990; Fosshage, 2003). Today most analysts seem to agree that we can accomplish therapeutic goals most effectively by variously blending analytic approaches rather than by rigorously following a unitary method. The application of this “mixed model” view by many testifies to analysts’ progress in thinking more open-mindedly and flexibly.

The deconstruction and reconstruction of earlier analytic concepts and practices has been far-reaching. Few if any of the original ideas and rules that guided classical psychoanalysis remain unmodified. Consider the classical triumvirate of abstinence, anonymity, and neutrality, for example, an unquestioned guide for analytic practice as late as the 1960s, with residual effects lasting much longer. Once striving to remain “abstinent,” contemporary analysts have become more participatory. True “anonymity”
is now seen as impossible, as we have come to realize that inadvertent forms of self-revelation are inevitable and that deliberate self-disclosure, once altogether proscribed, can be advantageous. Likewise, rather than trying to maintain a strictly “neutral” ideal, analysts are more apt to acknowledge and even express their unavoidable emotional and even passionate involvement in relation to their work and their patients (Hoffman, 2009). Even sacred cows such as “free association,” “precise interpretation,” and “transference neurosis,” the lattermost now criticized as iatrogenic, have been discredited and/or altogether dropped from psychoanalytic discourse.

These radical changes within psychoanalysis have set the stage for a more expansive rethinking of our approach to include extra-analytic disciplines and nonanalytic psychotherapeutic approaches. Yet since the 1980s and ’90s, when the foregoing evolution (or revolution) occurred, analytic innovation seems to have slowed to accommodate reconsolidation. However, notwithstanding our gains, many analysts continue to practice relatively traditional skills that are less than optimal in relation to patients’ changing clinical needs.

We can understand why change has been limited when we consider the ways some powerful psychoanalytic institutes exert their conservative influence. Senior colleagues who administer many of these institutes continue to appoint faculty members and supervisors only from the ranks of their own graduates, albeit ideally, at least, from among those most highly qualified. Many institutes’ teaching of alternative points of view remains something less than a priority, even an exception. Consequently, too many analysts cling to an established analytic protocol that is often the product of unduly narrow training and “inbreeding,” rather than openness to the most inclusive and cutting-edge thinking and methods.

Reinforcing these problems, at many training institutes, only authorized senior faculty holding the necessary bona fides are permitted to conduct candidates’ training analyses. Aware of the philosophy of their institute, and mindful of the didactic functions of the training analysis, many such analysts feel pressure to conduct candidates’ treatment “by the book”—a problem being that the training analyst, usually a product of an earlier generation, is sometimes most familiar with last year’s (or last decade’s!)
book. Many graduate analysts, at least early in their careers, tend to emulate their training analysts’ approaches. Under these conditions, a conservative bias is unavoidable. Is it any wonder that many prospective patients, rather than avail themselves of analysts’ services as they have come to know them, are attracted to more “user-friendly” treatments such as cognitive-behavior therapy and even life coaching that they believe will act more rapidly and achieve results that are more practical?

Specialization and Integration

Let us briefly recall the book review Aron discussed. Merkin described contemporary psychoanalysis as “having incorporated some of . . . [Freud’s] ideas and rejected others, [and] has in fact moved far beyond him, while neuroscience—in the form of M.R.I . . . evidence of unconscious mental processes—has been confirming basic tenets of analytic thought.” What she does not mention, however, is that neuroscience is corroborating the efficacy of many other psychotherapeutic modalities, such as cognitive-behavior therapy and mindfulness practice, as well (Kumari, 2006; Kumari et al., 2011; Linden, 2006; Beauregard, 2007; Etkin, Pittenger, et al., 2005; Ribeiro Porto, Oliveira, & Mari, et al., 2009; Hölzel, B., et al., 2011).

The next wave of significant change in psychoanalysis may well involve a far broader integration than we have known—one encompassing nonanalytic as well as psychoanalytic thinking and methods. Such an approach can remain based on the central ingredient of “deep” listening and the attendant process of transference-countertransference analysis, among other central analytic principles. Yet many psychoanalysts show little if any interest in expanding their practice in that direction. I have come to understand this exclusiveness by recognizing that during candidates’ formal training they become appropriately immersed in psychoanalytic learning. Candidates, having not yet achieved a solid grounding in their “mother tongue,” usually do not welcome “outside,” conflicting, and potentially confusing points of view and approaches. Depending on the openness of an institute’s pedagogical philosophy and its instructors’ attitudes, perhaps this temporarily single-minded focus is best for the analytic candidate. However, institute training can also serve as a form of
“indoctrination” into a closed form of psychoanalysis that stifles candidates’ ability to see new potentials for integrative applications, whether they are strictly analytic or more broadly based. A closed mental set, once having been established, can explain why so many experienced analysts, although more fully aware of the limitations as well as capabilities of psychoanalytic practice, take little interest in nonanalytic approaches that might enhance their analytic work. The result of narrow training can be a strict “psychoanalytic superego,” inhibiting and causing us to doubt ourselves when we “transgress” traditional forms of practice.

Another constraining factor is that when we follow our natural propensities, we usually choose to deepen our knowledge of the familiar rather than more expansively invest ourselves in peripheral, yet potentially promising, subject areas that may, initially at least, cause us to feel disconcertingly ungrounded. Besides, specialization is not altogether counterproductive and is attractive for several reasons. For one, busy practitioners have limited time for exploration and scholarship. Concentrating our efforts efficiently has practical value, although necessarily limits the breadth of our knowledge base. Many psychoanalytic theorists with relatively specialized interests—for example, the members of the Boston Change Study Group, who have forged new frontiers through developing original ways of thinking about therapeutic action—have made significant contributions. On the other hand, diversification and integration, while on the whole advantageous, introduce difficulties as well; if undertaken superficially or indiscriminately, they may fail to ground us and our practice in a deeply integrated knowledge of theory of the individual, of the therapeutic relationship, and of processes of change. Both in-depth specialization and broad-based exploration have a place in our field and are necessary over the long run. Ideally, these two approaches—specialization and integration—can be incorporated *dialectically* by looking deeply within our familiar forms of knowing and also toward others’ while aiming to strike the most productive balance.⁴

⁴I realize that an assumption I make here is ironic—that the knowledge we must draw upon from other disciplines is itself predominantly the result of an inward focus of scholarship.
We can view multiplicity and integration from several points of view—that among strictly psychoanalytic theories and methods, among coexisting analytic and nonanalytic approaches, and involving interdisciplinary studies. All are significant. Distressingly, analysts with particular institute or subgroup affiliations have little interaction with those associated with other schools. Members of the different schools (relational, self-psychological, and Lacanian, for example) rarely even cite one another’s work in their respective literatures. The relational revolution and especially Mitchell’s (1988) work, important as they were, were limited to an intra-analytic integration that blended diverse psychoanalytic approaches. Given that clinical psychoanalysis is above all a form of therapy and but one modality among many, the most spectacular instances of analysts’ counterproductive exclusiveness are our failure to benefit from progress made by our many psychoanalytic colleagues with different orientations as well as our counterparts working in other branches of psychotherapy. Turning to nonanalytic therapies, like analysts, practitioners of other therapy modalities also tend to isolate themselves, devoting passionate energy to understanding the mysteries of our overlapping subject areas, while sharing our primary aim—to benefit patients, but not information. Astonishingly, we all remain largely and complacently closed off from one another’s knowledge.

Becoming familiar with certain outside disciplines can have great value for analysts. Consider the cross-fertilization between basic and applied science in the recent dialogue between neuroscience (Cozolino, 2010; Schore, 2005), or interpersonal biology (Siegel, 2010), and psychotherapy. To analysts’ credit, we have discovered the potential contributions of neuroscience, the newest visitor to our all-too-often restricted colony of thought, shortly after functional brain imaging was developed as a means of understanding the relationships among the mind, brain, and personality and behavioral change processes. Examples include the knowledge gained from recognizing the role of neuroplasticity in personality change and how it can be fostered, and the significance of right-brain-to-right-brain communication between patient and therapist (Schore, 2005). Many therapists already have begun to apply preliminary neuroscientific findings to psychotherapy
In the past, when analysts have drawn from allied areas of knowledge, our reach has typically been short and we have done so timidly, favoring quasi-psychoanalytic sources like attachment theory, developmental psychology, and gender and feminist studies. Some bolder forms of interdisciplinary cross-fertilization also have occurred. Analysts have looked beyond traditional borders and drawn insights from philosophy, especially epistemology, that have deeply influenced our ways of thinking about what we do (Atwood, Stolorow, & Orange, 2011). As other examples, Slavin and Kriegman (Slavin, 2007; Slavin & Kriegman, 1990) have provocatively supplemented psychoanalytic theory with understandings from evolutionary biology, and Knoblauch (2005) from music. Although these alliances undoubtedly have spurred advances, there remain many other untapped knowledge areas, some quite remote from the analytic mainstream, to challenge and stretch our thinking. There is so much to gain from the immediately neighboring social sciences, such as academic psychology, sociology, and anthropology. Is it possible that clinical psychologists’ psychotherapy research tradition, including the psychodynamically oriented work of distinguished clinician/researchers such as Lester Luborsky (Luborsky & Luborsky, 2006) and Hans Strupp (Strupp & Binder (1984), among many others, have nothing to offer us? How enriched is the understanding of the analyst familiar with the history of positive psychology (Seligman, 1990; Kahneman, Diener, & Schwartz, 2003, for example) and its intellectual traditions of humanism, existentialism, and phenomenology, and the work of William James, Abraham Maslow, and Carl Rogers, among others? Experimental psychology’s learning theory also teaches analysts a great deal about the new learning that is implicitly involved in behavior and personality change; all therapists gain efficacy from knowing behavioral learning theory and its principles, such as behavior hierarchies and systematic desensitization. And cultural phenomena studied in sociology and anthropology probably contribute as much to the meanings of psychic life as do individual, including unconscious, influences.

These examples are among the more obvious sources of relevant knowledge. What about potential contributions from the
more distant yet potentially valuable hard sciences, and the disciplines of linguistics or ethology, for example, or the expressions of literature, poetry, the fine and performing arts, as well as the spiritual traditions, which are poorly represented in psychoanalysis?

Mindfulness and meditation, as further examples, have roots in spiritual practice far removed from the analytic tradition; yet they are found useful therapeutically in Dialectical Behavior Therapy (Linehan, 1993) and in other, including mindfulness-based, forms of psychotherapy (Hayes, Strosahl, & Wilson, 2012; Baer, 2006) as well as in psychoanalysis (Blackstone, 2008; Cates, 2011; Epstein, 1995; Preston, 2008; Safran, 2006). Relatively few of us have even heard of the new interdisciplinary field of neuroeducation (Battro, Fischer, & Léna, 2008). Its main interest is education. Its goal is to understand biological changes in the brain as new information is processed in order to clarify which environmental, emotional, and social situations can best facilitate processing new information. Clearly this nascent field has relevance to the change processes of psychotherapy.

The list of relevant disciplines is vast and humbling. It goes on and on, and much of its immeasurable knowledge is capable of expanding our analytic and therapeutic repertoires. However, no matter how intellectually capable an individual is, or how reasonably selective in making choices, one can scarcely begin to scratch the surface of this enormous body of knowledge. That is why interdisciplinary exploration and communication become so vital. For instance, some scientists have called the brain the most complex object in the universe (Cozolino, 2010). Can we ever thoroughly understand an organ capable of performing such a staggering number of calculations—ten quadrillion—in a single second (Godwin & Cham, 2012)? I doubt it; that complexity seems insurmountable. Yet using functional imaging techniques, neuroscientists have begun to make inroads into the parallels linking the functioning of brain and mind. The quest is justified; the analyst who draws understanding from other disciplines and approaches, rather than practicing a cordoned-off, single approach, has a broader and more informed basis for understanding and responding to each patient’s unique communications and therapeutic needs. Moreover, she models an openness and flexibility that, through internalization, itself benefits patients.
There are numerous valid and invalid reasons—historical, practical, pedagogical, political, and economic—why psychoanalytic and psychotherapeutic specialization through separate schools became established in ways that have discouraged a cross-fertilization of ideas. For example, Aron and Starr (2012) showed our insularity as partly the result of analysts’ historical need to define our discipline in opposition to the “other”—hypnosis and suggestion at first, then psychotherapy, among sets of other binaries. That same observation can be made about other modalities: cognitive and behavior therapy, for example, which originated in opposition to psychoanalysis. Serious divisions and problems have resulted. Take the currently popular and useful way of conceptualizing in terms of schemas in psychoanalysis. Aron Beck (1967) introduced the schema concept in cognitive therapy more than a decade before analysts came to appreciate how we might usefully apply it within our customary frameworks. A pivotal paper by Paul Wachtel (1980) was probably the earliest psychoanalytic attempt to articulate the value of conceptualizing in terms of Piagetian schemas, assimilation, and accommodation, which is not surprising, since Wachtel is a widely knowledgeable pioneer and creative advocate of psychotherapy integration. Had there been better exchange among modalities, quite possibly psychoanalytic knowledge would have advanced more rapidly.

Resistance to innovative ideas has a long history within psychoanalysis. Recall the furor caused by Franz Alexander (Alexander & French, 1946) within the American Psychoanalytic Association. His innovative ideas about experiential factors, especially the mutative role of new relational experience—which, as we know, eventually became highly influential—clashed with the widespread commitment to a one-person psychology, orthodox practice, and the need to protect psychoanalysis as an ostensibly medical–scientific project. Yet with clinical and research (Weiss, 1988; Weiss & Sampson, 1986, for example) corroboration, the basic assumptions underlying Alexander’s approach have found their way into our theories. That institutionalized resistance, ostensibly based on “good science,” obviously was detrimental to progress. It demonstrates the powerful role of temporality and

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5Because cognitive-behavior therapy and analytic therapy form very different contexts, different definitions and applications result, of course.
the context-dependent nature of “truth,” the latter shaped powerfully by sociopolitical, economic, and other subjective factors. Context determines what ideas will originate, how they become organized and judged, and how they are used. For instance, currently, certain basic research findings are more readily accepted by some analysts than are others; some of us prefer to look to mother–infant interaction studies (Beebe & Lachmann, 2002; Beebe, et al., 2012), for example, and some to neuroscientific research. Which, if either, promises to be the more productive over the long run, and why? Both areas have intrinsic value for clinicians, and we should glean what we can from both.

Shortly, I will illustrate how certain so-called nonanalytic methods can potentiate specific functions that play a key role in analytic change—sometimes better than psychoanalysis itself can. For now, let us briefly consider the progressive “psychotherapy integration movement,” which began concertedly in the 1980s. Although that movement is robust, unfortunately, a disproportionately small number of psychoanalysts participate actively in that movement. A strong reason for analysts and others to expand and integrate various methods is that the therapeutic action of psychoanalysis and psychotherapy, generally, comprises many interrelated processes. Encompassing inner and outer worlds, many processes of mind, body, behavior, and context collectively account for personality and behavioral functioning and change. Certain specialized psychotherapy methods—psychoanalysis being but one among many—are more capable of activating certain processes that participate in change than other methods.

Recently some psychodynamically oriented clinicians have begun to explore other fresh approaches drawing from the area of trauma studies and their implications for broader treatment (Shapiro, 2012). Unfortunately, some “founders” of these newer, effective areas of trauma work tend to maintain a proprietary, somewhat entrepreneurial attitude toward their material. From a desire to assure trainees’ clinical proficiency, they have “branded” their approaches and, in my opinion, made them unnecessarily
difficult to access through time-consuming and expensive certificate training programs for prospective practitioners. Although these techniques could advance the cause of psychotherapy integration, their training models instead create an unfortunate by-product—by limiting the accessibility of these modalities, they perpetuate the fragmentation that has been so detrimental to the field of psychotherapy.

**Multiplicity, Contextualism, and Psychoanalysis’s Hybrid Identity**

In absorbing a widening range of source data—from philosophy and from neuroscience, for example, or from case studies as well as systematic psychotherapy research—psychoanalysis builds on its hybrid nature. Reaching understanding through multiple forms of knowing, say through data-driven as well as theory-based practice, creates a challenge to any discipline and at times has been a divisive factor in psychoanalysis. Rather than a more balanced evaluation and integration of knowledge, in virtually all fields such diversity tends to lead to counterproductive polarization, with derisiveness toward opposing notions that are perceived as misguided, inferior, or limiting—in our field, between opposing extremes of scientism versus radical relativism, for example.

Given our individual experiences in training and our personal biases, it can be difficult to grapple in earnest with multiple sources and kinds of data, methods of inquiry, and theory in order to integrate what may seem dissimilar or unfamiliar—to weight and to place diverse data in perspective. It is undoubtedly less challenging to privilege a single source of data or school of thought while dismissing competing forms. But can we achieve a more comprehensive understanding without casting a broader net in our search for relevant information? I think not. Following an insular course is simply too limiting, and ultimately our patients pay a price. Returning to the example of neuroscience, some analysts all too predictably eschew these findings and the light they can shed on analysis, viewing them as excessively reductive and arguing in a polarized way for the abstract nature of mind and more strictly intersubjective sources of data. Others embrace such new information enthusiastically, at times indiscriminately, as proof positive of psychoanalytic truths. Neuroscience’s
most zealous proponents must keep in mind that, at best, isolated findings must be interpreted probabilistically and contextually, and depend on corroboration by additional data. As Jaak Panksepp (1998), the father of affective neuroscience, pointed out, the science of the human brain is in its earliest stages, and often the hypotheses and conclusions of neuroscientists are somewhat linear and perhaps simplistic. That does not mean we ought to ignore such findings out of hand, but that in applying them we must evaluate them thoughtfully for their validity and utility. For now, we are wise to hold these findings loosely, tentatively, while continuing to keep up with the research and its potential ramifications for analytic work.

When we speak of interdisciplinarity, we are speaking of interdependence and mutuality, with progress in communicating disciplines being coextensive. The basic scientist, in order to master the operations of the brain, must also know, among other things, how his human subjects feel, behave, and are motivated. He can observe behavior more or less objectively, but not the consciousness of another individual; nor can he directly know what an individual’s underlying motives are. Here subjective and inferential data are essential, and psychoanalysis as an interpretive art can provide supplemental and crucially validating data. Just as clinicians benefit from information on brain functioning, reciprocally, neuroscience researchers most fully understand the functioning of the brain by making reference to individuals’ corresponding subjectivity. The challenge for analysts is to remain open to finding a middle ground between objectivism on one hand and subjectively interpreting more intangible data on the other. The dialogue that addresses extreme claims on absolute truth or on the superiority of certain forms of knowing over others can either advance or interfere with psychoanalytic progress. That will determine our future.

“Consilience”

The term and concept “concilience,” introduced by William Whewell in 1840, was largely overlooked until it was revived by biologist Edmund O. Wilson (1998) as “a seamless web of cause and effect.” Wilson asserted that the sciences, humanities, and arts have a common goal: to give purpose to understanding the
details, to lend to all inquirers “a conviction, far deeper than a mere working proposition, that the world is orderly and can be explained by a small number of natural laws” (p. 291). If Wilson’s holistic position strikes one as overly reductive, as it does me when viewed through the lens of the social sciences and psychoanalysis, it has value through its interrelating of seemingly independent, complex systems. Daniel Siegel has productively resurrected this holistic concept in his “interpersonal neurobiology” (Siegel, 2012).

A consilient view recognizes that evidence from multiple sources can converge to strong conclusions, and that we gain the most when we learn how processes weave through different systems—brain, mind, body, and community, for example. We benefit from thinking about the individual mind as more broadly contextual than simply dyadic, as contemporary psychoanalytic theory tends to emphasize. The individual functions in a sea of interactions of multilayered and contiguous systems, both internal and external, some identifiable and others not, some that covary and others that do not. Collectively, these multiple influences shape our mental lives and the worlds we live in. As we consider individuals’ ways of being in a world of multiple, interacting systems, we become more curious about the multitude of variables affecting us and how a broad knowledge of them might inform our work beneficially.

One example is the biopsychosocial understanding of individual functioning, a commonly recognized, relatively simple, tri-systemic unit. According to this view, three broadly conceived and interacting systems (actually, encompassing infinitely more) can be understood vertically and horizontally. The biological system includes among its many functions the firing of neural pathways, endocrine secretions, and other somatosensory processes associated with heart rate, blood pressure, and literally all the bodily systems. In a nutshell, the psychological system encompasses states of mind involving sensations, cognitions (such as attitudes, expectations), images, affects, and action tendencies. Social processes involve the external physical and, especially, human surround, including two-person to multi-person phenomena, ordinary occurrences to unexpected and overwhelming traumas, local to global happenings. All are of contextual interest to analysts. Beginning with individual systems, dyadic and then other
systems of greater and specialized complexity form and build upon one another—individual systems become dyadic, which in turn become triadic, and so forth. At any given moment, all these systems, ranging from individual physiology to global relations, interact with one another and have impact on us in complex ways. Many forms of self-construction and co-construction of meaning, while often understood as causal, are also end points of complex physiological–social interactions routed in evolved regulatory systems responding to such processes (Panksepp, 1998). Even this very basic tri-systemic unit implicates a wide range of instrumentalities that we can study at various levels for their therapeutic relevance—bodily sensations, affect, imagination, logical thought, attitudes, and interpersonal behavior, family and community events, global politics, and many others. This overall perspective, as well as knowledge of any one of its elements, can help us better understand how things can go wrong, how they can go right, and how we can modify them.

How narrow a dyadic—no less monadic—unit of study appears from such a perspective! Granted, analysts’ influence is primarily concentrated in the dyad, but multiple sources of information drawn from the extra-analytic as well as the analytic world must, at the very least, inform our thinking and interventions. Although analysts most often concentrate on patients’ continual re-creation of their subjective worlds, a broader systems view recognizes that these worlds are not only the creative consequences of patients’ inner processes but also create conditions that maintain the processes of inner life. Just as people actively define, by acting on, their worlds, so do their worlds act on and define them. These inner and outer worlds co-create, interpenetrate, and transform one another through a myriad of subtle transactions occurring within a vast, complex network that is infinitely wider than the analytic dyad.7

When we consider the individual as a part of the overall field, we realize that an assessment of clinical efficacy based solely on alleviating psychopathology, on reshaping the patient’s internal world, or on changing the nature of one-to-one interactions is

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7In a forthcoming publication, Kim Bernstein described the “psyche-soma-mundus,” referring to the inextricability and interpenetration of mind–body, body–world, mind–world, and vice versa.
insufficient. A much broader template is far more serviceable—one reflecting outside life and communal change that incorporates but is not limited to psychic change. We expand our focus to patients’ (and analysts’) lives beyond the consulting room and consider psychoanalysis as a treatment that emphasizes people as agentic, as becoming in the world. We include an emphasis on positive psychology and ask ourselves how well we have advanced the individual’s sense of possibility, resources, strengths, and virtues like courage and the capacity to love that enable him or her and society to thrive. Such a view stresses patients’ creativity, actions, and personal values and ethics. It shows the value of reaching beyond the ideas of formal psychoanalysis and its heavy focus on psychopathology to the more positive concepts from nonanalytic therapies like transference (Fosha, 2008), or carrying forward or living forward processes (Gendlin, 2004).

Analysts must reach beyond strictly psychoanalytic and quasi-psychoanalytic specialties to extra-analytic ones. By becoming less inward-looking and noticing especially the many new ideas emerging at the margins of our very own discipline and in the world beyond, we are enabled innovatively and creatively to bring others’ insights and questions into dialogue with our own traditions. We have much to learn through consilience and an integration of multiple and diverse ideas and, especially, from those practicing other psychotherapeutic specialties. The sharing of discoveries, knowledge, and common findings, especially among representatives of independent modalities, must become commonplace rather than the exception.

A Vision: Some Clinical Implications

Now let us turn explicitly to a vision for the future. In addition to providing the individual with an experience of feeling deeply understood, the primary goals of psychoanalysis include, among

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8According to Fosha (2008, in K. J. Schneider, Ed.) transference is hard-wired, overarching motivational force, operating both in development and in therapy, that strives toward maximal vitality, authenticity, and genuine contact. According to Gendlin (2004), each move, from the pumping of the heart to discussing psychoanalytic theory, implies the next step—an organic carrying forward process that, at each moment, is possible to feel. With specific training, one can learn to attend to this feeling more deeply, so that a holistic felt sense of a whole situation can form.
other functions, successfully facilitating the individual’s formulation of unformulated experience (Stern, 2003) and bringing problematic interpersonal patterns to awareness. The comprehensiveness of analysis is based on processes related to its relational intimacy and narrative engagement of a wide range of the individual functions and resources involved in change—verbal and nonverbal, direct and identificatory, sensory-motor, affective-emotional, cognitive, imagistic, wishful, behavioral, and others, all undergirded by accompanying changes in neuronal patterns. This uniquely broad range of activation defines analysis as a desirable nucleus into which to integrate other modalities. For although the narrative of psychoanalysis may offer the most comprehensive approach to personality change—and at least one neuroscientist confirms that impression (Cozolino, 2010)—that does not necessarily preclude other modalities from activating certain specific functions of therapeutic action, including those of psychoanalysis, more adequately than analysis per se. Among its limitations, being heavily dependent on verbalization, analysis can fail to tap body memory and the body’s basic affects efficiently, or to facilitate new action as a source of change. I will show how the integration of nonanalytic modalities (specifically, cognitive-behavioral and Focusing therapy, in this instance) accomplishes these goals.

As Messer (1992) originally defined it, “assimilative” psychotherapy integration is a form based on the synergistic incorporation of practices and perspectives from other schools of psychotherapy into one’s own therapy orientation. This form of integration allows psychoanalysts to maintain their preferred perspective on psychotherapy while drawing flexibly on the wisdom and methods of other schools in order to enhance the quality of therapeutic benefits. As long as this practice does not violate—and at times even enhances—basic psychoanalytic tenets, assimilative integration allows us to practice in a manner that is theoretically integrated. Technical eclecticism may offer a practical solution, allowing the clinician to avoid having to find a connection between

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9Other approaches to psychotherapy integration are the “common factors” approach and technical eclecticism, the latter based on research evidence rather than theory. The interested reader may wish to refer to Norcross and Goldfried (2005).
techniques and their conceptual underpinnings, but this reasoning is unacceptable to analysts, for whom clinical work and theoretical commitments are inextricably linked. Analytic integrationists emphasize theoretical over eclectic, or mere technical integration, incorporating not only *that* these combinations of methods work but *how*.

A contextualist view of integration suggests that psychotherapeutic concepts and interventions can be understood only within the linguistic, theoretical, and ideological frameworks in which they are embedded. When an external process like cognitive-behavior therapy is introduced in a new context such as psychoanalysis, both change. The consequences of such practical integration on analytic theory are seen in the modification of analysts’ thinking in terms of affective-cognitive schemas (Singer, 1985; Stolorow, 1995, for example). Integrating cognitive-behavior therapy with analysis reinforces an extension to affective-cognitive-action schemas (Frank, 1999; Slavin, 1994). This broadened conceptualization, taking action potentials into account, makes more sense in terms of the way people actually function and change, and subtly shifts the way the analyst works.

From both assimilative and contextualist points of view, knowing nonanalytic methods provides the therapist with a clinical advantage. For instance, when limitations on session frequency limit intensiveness, nonanalytic methods may provide it by using other means, such as cognitive-behavior therapists’ asking patients to keep records that closely account for their moment-to-moment experience (activating events, feelings, thoughts, images, behaviors) in certain situations outside of treatment that are fraught with anxiety. With such homework assignments to supplement sessions, therapists offer something that is not only compensatory but different, and at times more effective than listening in depth. In other instances, cognitive-behavior therapy can supplement psychoanalysis by extending treatment’s reach through aiding a patient in taking action in the external world—something traditional psychoanalysis does not emphasize and historically even opposed. Promoting new action can lead to and reinforce change by fostering alternative new behaviors, including improved self-regulation, and by helping to modify interpersonal and other behavior and feedback patterns. Change in one—affect, cognition, or action—leads to changes in all. In selecting from the many
modalities, we do not face a dichotomous, either/or choice; we need not commit exclusively to one among multiple therapeutic approaches, but can implement several.

As an example of using cognitive-behavior therapy with analysis, consider a patient whose angry outbursts toward his wife brought him to therapy. His circumstances were such that he could only commit to once-weekly sessions. I decided to use cognitive-behavior therapy methods to augment analytic therapy. Early in treatment, I asked him to keep an “anger journal,” to help him attend to, record, and examine his anger outbursts in vivo, in close proximity to their occurrence. He recorded (a) the triggering event or social setting, (b) his feeling/s, especially anger, with intensity ratings, (c) accompanying conscious, or “automatic,” thoughts, and (d) his outward reactions: displays of anger or other behaviors. Through explorations that included these data, we learned that he was processing what we came to appreciate as his wife’s needs for reassurance of his affection as expressions of her mistrust of him. There was a context for his meaning-making; he scorned his neglectful father, seen as a philanderer and ne’er-do-well who abused him and his mother. Because the father was an emotionally charged object of determined counteridentification for my patient, he felt he had to “counterattack” what were, in his view, his wife’s humiliating insinuations of his being “just like my father.” As we elaborated the dynamic that was in play in his relationship with his wife, which included my encouraging his taking a more empathic view of her, I also taught him self-calming methods, specifically, deep muscle relaxation with slowed diaphragmatic breathing. In a state of relaxation, he would then imagine in session (cognitive-behavior therapists would say “cognitively rehearsed”) alternative and more empathic responses to what he had taken previously as her insults. As his anger diminished, he was able to openly experience and manage feelings of vulnerability rather than express defiance, and to respond more constructively.

When we synergistically add modalities defined as nonanalytic to analysis, they become analytic, in effect. The patient described above, who arrived with a tendency to feel abused, came to realize the origins of his interpretations and discussed how I, in contrast to his father, was helping him become a “bigger and better” man (a new relational experience), which
he appreciated on many levels, including his internalizing being a better father as well as husband. Working on other issues in ways more traditionally analytic, he became aware of the ambivalence that arose in giving his son more than he himself had received as a boy. Integrative analysts certainly need not reject an emphasis on what we might call deep listening, but retain it as a central component of a profound, intimate attachment that forms a core for developing and applying additional interventions (Frank, 1999).

Integrating cognitive-behavior therapy, especially in its more recent constructivist (rather than rationalist) forms (Guidano, 1991; Mahoney, 1995), accords with my longstanding belief that analysis happens in real time—a consideration in conflict with our analytic forebears and their anti-action stance. We can integrate cognitive-behavior therapy to facilitate patients’ capacity to initiate the constructive actions certain insights demand (Frank, 2012). When we examine what we actually do in the consulting room, we recognize that we have long used so-called nonanalytic modalities analytically, which softens our psychoanalytic superego. By actively learning the rationales and methods of other modalities and the ways they interface with our theories and practices, we become more proficient with them and more likely to use them. Moreover—and this is a crucial point deserving emphasis—analysts can utilize many nonanalytic methods synergistically without diluting or compromising psychoanalytic integrity in any way, including retaining, even expanding the potentials of the centerpiece of psychoanalysis: transference-countertransference analysis and the dialectical new relational experience that arises from and complements it.

**Neuroscience, Cognitive-Behavior Therapy, and Mindfulness-Based Experiential Therapy (Focusing): “Top-Down” and “Bottom-Up” Ways of Understanding Change**

When an individual’s cognitions, affects, sensations, and behaviors become differentiated and operate as an integrated whole, the individual approaches optimal psychological functioning. On a neuropsychological level, we see a parallel in the intercommunication and harmony among specialized neural networks that operate
on many levels. Higher cortical functions, such as learning, conceptualization, and executive functions (attention, memory, and verbal reasoning, among others), are shaped and reshaped by experience: that is, are subject to neuroplasticity—the process whereby the neural pathways and synapses of the brain are subject to change from new experiences of various sorts. We can think of self-regulation as resulting from a balance between cortical and subcortical functions. Affective dysregulation occurs when the balance tips in favor of subcortical activation.

We might consider cognitive-behavior therapy, which depends predominantly on higher cortical functioning, as a “top-down” approach. It assists the patient in bringing the influence of higher cortical (usually left brain, verbal) functions into play to cope with lower-level functions, such as the amygdala’s and limbic system’s primitive arousal system. Much of the insight, reframing, and self-regulation achieved in psychoanalysis depends on such top-down, left-brain-dominated processes, with patients and therapists observing and commenting on known features of patients’ emotions, motives, and actions. Top-down methods are most effective when patients are functioning within mid-range levels of activation, or arousal, but also may help patients achieve these levels of self-regulation. They can help to “up-regulate” a hypo-activated, deeply depressed person or to “down-regulate” one who is hyper-activated, say, agitated or panicky.

Illuminating “bottom-up” moments also occur as part of the analytic process, arising from anatomically lower brain areas, such as the somatosensory functions of the limbic area, and the non-verbal right brain. From a neuroscientific perspective, emotions form in the subcortical systems and are often experienced in the body as affects before entering consciousness (Damasio, 2000), where, unconsciously they can have significant effects. Bodily based affective experience tends to serve as scaffolding on which subsequent, consciously experienced feelings are built. The individual experiences from deep within in unlearned ways that are as direct, instantaneous, and neutral as possible, such as immediate sensation.

In addition to Focusing therapy, Sensorimotor Psychotherapy, Somatic Experiencing, and other mindfulness-based modalities can be thought of as “bottom-up,” right-brain-dominated therapy modalities. Some, such as Action and
Commitment Therapy, or ACT (Hayes, Strosahl, & Wilson, 2012), draw from both. Mainstream psychoanalysis has privileged explicit memory, but for some patients, including many with early relational trauma, the body contains and holds relational conflicts. These patients, in particular, do not have the language to describe their feelings; instead, the relational conflict is held in the body, the starting point for emotions. Often, especially in instances of early trauma, the body is seen as the portal for verbal exploration. These body-based, bottom-up methods can often access implicit material—what we have called preconscious or unconscious material, or primary process—more efficiently than the co-narration of analysis alone. Working in these modalities, patients’ mentation often has a different quality—less processed, more associative and fluid, naive, affectively charged, or childlike. The immediacy, apparent depth, memories, and symbolic associations that arise can usefully deepen and extend the narrative explorations of psychoanalysis in a manner often similar to the referential process that Bucci (1997) has outlined. Blended with analysis, these methods facilitate neural and personality integration.

Let us specifically consider the somatosensory-based method of Focusing. While calling attention to bodily sensation and tracking the process through which experience becomes conscious, Focusing helps the individual formulate implicit processes. Bodily sensations are initially felt and sensed rather than thought about and formulated (top-down). One’s abdomen may feel tight, one’s torso dark and heavy or light and airy, for example. Sensations may stimulate evocative images and associative memories and become progressively elaborated. When focusing, the individual may experience an element of surprise as she realizes what has been affecting her. For example, in a receptive state of self-observation, the adult self may engage the relationship to an infant self or internalized childhood figures through inner dialogue. Similarly, one may imagine animals that, acting as if they have a will of their own, enact parts of the self in a manner suggesting a reworking of old schemas. As states change, one senses fluid bodily and mental shifts and may sense oneself descending, rising, lifting off the ground, or soaring, for example.

With some work to prepare the patient and an introduction like, “If you feel comfortable doing this, let’s take some extended time with that feeling,” the Focusing-trained analyst can engage
the patient in a sustained period of explicit Focusing that works synergistically with the natural flow of analytic material. Such applications can be likened to the way many analysts approach dreams, by exploring “disguised,” or implicit meanings, and attempting to promote their formulation, sometimes devoting an entire session or several sessions to that work. As a case example, consider a long-term patient of mine, a middle-aged man whose elderly parents are in declining physical health. He was disturbed to find himself unable to experience feelings of sadness over his mother’s imminent death. As background, his mother, a highly intelligent and well-educated woman, nevertheless spent her life under the thumb of her dominant husband, my patient’s father. A central theme of my patient’s therapy was to free himself from his father’s strong critical influence. Now the mother remained in bed, withdrawing socially, and neglecting her self-care. The father, in contrast, remained robust in the face of physical and psychological decline, arousing deep admiration in his son. Despite interpretive efforts and even a suggestion that he begin to prepare his mother’s eulogy in order to connect with his feelings—a task he would not undertake—my patient remained guilty over a continuing “hollow” feeling about his mother. We decided to try Focusing to help him explore and possibly deepen his experience. We had employed it usefully a few times before and, unlike a trial experience with EMDR, he took well to it.

The following account of our work is abbreviated. A Focusing therapist acts as a sort of companion, offering a holding environment that nonintrusively nurtures the patient’s internal process. Much of the therapist’s activity is to show resonance with, by repeating the focuser’s words so the latter can refine and better formulate them (or sharpen their emerging, unformulated or “murky edge”) for herself. This process is explained to the patient beforehand to account for the therapist’s modified participation. The focusing session lasted about 25 minutes and began with the patient noticing a feeling of tension in his chest and shoulders. (KF: “Sensing some tension there. Just let it know you’re aware of it and maybe hang out with it with interested curiosity.”) Attending to those feelings as they move, shift, and develop, the patient becomes aware of a vague sense of anger. (KF: “Sensing something in you that’s angry.”) He acknowledges, “yes,” and stays with his anger, which crystallizes into “feeling an impulse to punch.” After
a self-exploring silence, he senses it is associated with his mother, whom he pictures lying in bed. (KF: “So you’re sensing the anger feels associated with your mother.”) He nods. Now he describes visualizing himself standing over her as she reclines in her bed. He reports feeling angry and disdainful of her for indulging her weakness rather than “sucking it up” and helping herself get up, get dressed, and live what remains of her life. (KF: “If only she would live what remains of her life!”) He agrees, “Mm-hmm.” He imagines himself continuing to stand at her bedside, silently sensing his experience. (KF: Feeling he may need a prompt, “Maybe bringing that sense back to your body?”) He becomes aware of a tensing in his lower back. Staying with that sensation, he senses an impulse to turn from her and imagines himself shielding his eyes from her with raised hands, palms forward, twisting his body as if pushing away from her. (KF: Expressing curiosity, “Hmm, sensing you want to turn from her.”)

Staying with the image and sensed inclination to turn from her, he first describes an impulse to leave and sees himself moving away from her bedside. Then he notes, “The anger disappeared.” It returns, and again diminishes, this time gradually (Pt: “I sense it softening”). He describes feeling drawn to looking at his mother, his anger dissolves altogether, and he begins to feel warmth. In his chest, he discovers another part that feels for her and wants to stay with her. (KF: “Mm-hmm. Feeling warmth and wanting to stay with her now.”) He agrees, notices, and remarks on how these conflicting parts co-exist—the wish simultaneously to turn away and to attend to her. (KF: “Both are there. Maybe you’d like to attend to one?”) He chooses to be with the “pushing away” part. What he doesn’t want to see most, he states tentatively, is her frailty, distress, and inability to summon her resources to help herself. (KF: “Mmm. Not wanting to see she can’t help herself . . .”) He pauses for a long while, is motionless, seeming to be doing internal work, and then says he realizes he doesn’t want to “let in” his feelings about her. He first describes feeling “numb,” “hollow” again, which lasts for a minute or so, then describes an impulse felt in his biceps to reach out and an opening of his heart. (KF: “. . . sensing yourself opening to her.”)

That awareness strengthens and gradually develops into a feeling of compassion. He wants to reach out to touch and soothe her, but he is caught between inclinations to soothe and to turn
away. He lingers at that choice point for 30 seconds or so. Then an insight occurs to him: He cannot stand to see her showing what he hates in himself, a lack of courage, strength, passion, a willingness to “fight for something.” Following a prolonged silence, there is a shift, and he says, with a sense of resolve, “I want to comfort her. She hardly has any strength or resources left.” He now imagines her differently, helplessly, and his eyes fill with tears. After a few minutes he composes himself, seems lighter, more relaxed, and says, “I’m reluctant to feel for her, like her, be like her. But I realized, now we’re different. I’m not really like that anymore.” He pauses again, taking deep breaths, says smiling, “I feel my strength filling me. I have an image of myself as a superhero, rising up, flying. To the rescue!” He laughs, and so do I.

He “returns to the room,” and we rehash our work in the time remaining. As the session ends, I summarize that his differentiation from his mother and realizing he is no longer so much like her gives him strength and seems to enable him to soften to her. He acknowledges he can now reach out to her through strength, without resonating with her by feeling weak. At his next session, I learn that he has paid his mother a visit (a two-hour drive each way), a highly unusual action for him. While visiting her, he says he felt compassion for her and tells me he senses it probably is connected to the Focusing. As we continue our work, subsequent sessions reveal that he can now better accept loving feelings and anticipatory grieving for his mother. This Focusing experience and its dramatic behavioral follow-up occurred in the setting of a deeply intimate analytic relationship that has lasted for several years. It develops from all that has come before and shapes the analytic work that follows. The patient is a good candidate for this method. Although many patients have less dramatic experiences, Focusing usually advances the work of psychoanalysis, and in my experience has never been harmful.

Considered neuroscientifically, conditions of arousal and attentiveness foster neuroplastic reorganization (Cozolino, 2010). This occurs as Focusing patients access the lower brain centers’ and right brain’s “intelligence,” if you will, more efficiently than in customary “talk” therapy, which, as noted, privileges the left-brain’s explicit functioning. Focusing experiences blend well with the ongoing analytic process, and often patients’ bodily sensations, symbols, and associations can be utilized potently as
reference points—as applied to the case example, I might say, “Like that experience you had while Focusing of being afraid to let your warm feelings in.” The goal of both top-down and bottom-up approaches, in terms of the neuroscience involved, is to forge new multidirectional integrations of neural circuits and connections that are both up/down and left/right, to effect harmonious (integrated) functioning among affect, cognition, and behavior.

Focusing and certain other mindfulness-related methods like Sensorimotor Psychotherapy and Somatic Experiencing that I do not go into here can similarly be utilized seamlessly with analysis, as they often hasten and bring distant experience closer to awareness. The analyst may learn to recognize signs of a patient’s spontaneous “felt sense” arising during conversation as a patient gropes for words and gestures toward the body’s center. Or the therapist may become sensitized and call attention to motor or other physical signs and sensations, such as fist clenching or a tightening of the mid-body. Using this information, the therapist may be able to help the patient become more aware of the meaning of those sensations with such minimal interventions as an invitation to stay with, in order to clarify the experience. The therapist might say, “You’re sensing something unclear there in your body. Maybe we can spend some time with that and see what’s coming up, what wants your attention, what it’s about?” Through such psychotherapy integration, we sometimes can accelerate the process of change—and again, I reemphasize—without violating basic psychoanalytic tenets.

On their face, mindfulness-related practices like Focusing may seem unrelated to analytic therapy. Yet in an investigation that appeared in the journal Neuro-Psychoanalysis, Lane and Garfield (2005) explored these methods and their neuropsychological correlates. Relying on neuroimaging data, they examined the neural substrates of implicit aspects of emotion, background feelings, focal attention to feelings, and reflective awareness of feelings. They concluded:

Attending to background feelings can lead to a more intense and authentic phenomenal experience of emotion than simply labeling a feeling state . . . . This approach to the focus on bodily states in psychotherapy as a source of new emotional information . . . [reveals] striking correspondence to the neuroanatomical evidence . . . [and suggests] that analytic
attention to the process by which emotion comes into awareness may be much more central to the analytic task of investigating and eventually reworking the unbearable affects that bring patients into treatment than has been previously recognized (pp. 23–24) [italics added].

In effect, these authors offer an improved, more potent understanding of insight than in traditional psychoanalysis. Beyond merely identifying and naming emotions, there is greater value in an analytic process that emphasizes patients and therapists paying attention to bodily processes and how they participate in the gaining of emotional awareness. This study illustrates how basic neuroscience can inform and enrich clinical analysis through understanding and integration of the therapeutic action of nonanalytic modalities. It also demonstrates the multidisciplinary benefits of the coming together of diverse understandings of experience—in this case, cognitive, developmental, neuroscientific, and psychoanalytic—that I am advocating.

**Conclusion**

I am sounding an alarm. Psychoanalysis has gotten itself into trouble, largely because of its unreflective insularity. I am arguing for the need to open analysis further, especially to outside disciplines and methodologies, to enhance its strength, effectiveness, and even viability. Acting in an elitist manner, many of us ignore and even disparage outside approaches, without adequately understanding their underlying rationales, let alone their similarities to and differences from analysis. But the reality remains that there are numerous other strong and effective modalities that are often viewed as our competitors by outside observers, including potential patients, as well as by many analysts—to the detriment of all involved. I have shown how elements of these modalities can be effectively integrated into, and strengthen, psychoanalysis.

If we are to live up to the promise of relational psychoanalysis, we can and should open ourselves to integrating other disciplines, modalities, other perspectives, approaches, and fields of inquiry. I have selected two nonanalytic psychotherapy modalities for illustrative purposes, that on the surface could not seem more different. There are many others, but these two particular ways of supplementing analysis appeal to me as the result of my
personal and professional background, sensibilities, and clinical experience. Based on similar considerations, other analytic practitioners can make choices of their own from an expanding range of possibilities. Ideally, we will become far more open and inclusive of alternative ways of thinking and working than we are now. For by continuing to ignore and marginalize other modalities and disciplines, I fear we are assuring our own marginalization.10

References


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10 As I come to the end of this paper, I am aware I have offered a very narrow sampling of the wide range of relevant information now available to us. In the future, I hope to edit a volume compiling the psychoanalytic insights of an array of scholars from other disciplines and nonanalytic schools of psychotherapy. Their thinking, originating from beyond our traditional borders, would undoubtedly be of great value to us.


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