Editorial: Notes from behind the couch
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Take This Pill:
The lost value of the “specific factor”

The difference between a medical practitioner and a medical patient is clear. The practitioner knows certain things about the workings of the patient’s body that the (typical) patient does not. This knowledge provides a distinct understanding that allows the doctor to reinterpret the patient’s presented symptoms and subjective experiences (e.g., complaints, pains, etc…). This reinterpretation takes the form of a cohesive diagnosis of the patient’s physical condition. A sore ankle is interpreted as an inflamed Achilles tendon; an irritating itchiness is interpreted as an allergic reaction. A diagnosis might not resemble the patient’s subjective account his or her own body, but this lack of connection between the patient’s and the doctor’s perspectives makes for an important aspect of the treatment process, in medical treatments or psychotherapeutic treatments.

In some cases, a patient can be inspired by trust, on experiencing his doctor’s explanation as being beyond what he can easily understand—the distance or inability to understand fully can be a measure of the doctor’s “expertise” or specialised knowledge. However, such a lack of connection also demands a corresponding degree of faith from the patient to endure the strange, or seeming-unrelated aspects of treatment, at least until the symptoms show improvement. We endure a shot in the arm for a pain in the stomach, but the ultimate improvement in stomach pain dissolves all worry or care over the distance between the arm and the stomach.

Students of medicine and of psychotherapy alike are usually advised that the patient’s acceptance of, and adherence to, the doctor’s treatment bodes well for prognosis. To this end, especially in psychotherapy, the practitioner will take the time to explain the specialist understanding of the patient’s condition in ordinary terms, until the gap between symptoms and treatment is somewhat lessened. Some treatments require more of this explaining than others, some involve prescriptions more removed from the patient’s common-sense understanding. Among the clearest examples of the size and value of such translations or interpretations is that of the prescription of medication.

Take this Pill
When a patient complains of an extremely sore throat, fatigue, and heat symptoms, the doctor might prescribe an antibiotic medication. Here the treatment involves absolutely no common-sense link to the problem, although most patients can content themselves with some rudimentary and quasi-medical knowledge to bridge the gap. But when the doctor urges you to take a pill, you agree to a treatment that does not focus on the presenting problem as you see it, and might approach the more extreme versions we see in alternative medicines, where, for example, excessive sweating of the torso might be treated with acupuncture to the big toe and shin. We trust the doctor or acupuncturist to know their language, and this allows us to acquiesce to the procedure that no longer focuses on our torso. So, how might this problem of the necessary but discrepant understanding of the patient’s problems apply to psychotherapy—a treatment that almost all researchers and practitioners agree should foster the “common factor” of shared understanding of both problem and treatment (Bambling & King, 2001) for its therapeutic effect, regardless of the form of treatment in question? If all treatments ask the patient to take a pill in some form or another, will psychotherapy patients demand to understand the treatment in a way that medical patients do not?

Sullivan is often cited as having said that the least we should be able to offer our psychotherapy patients is a new perspective. We might begin to wonder whether a new perspective is in fact necessary, or perhaps whether it might be sufficient inasmuch as it
constitutes the essence of what patients get from their psychotherapists. To be sure, there are some patients who can get quite upset with us if we add too much to their story, beyond an affirmation of their own, pre-existing perspective on it. This has been spoken of in the literature, in terms used by Kohut, as the patient who needs a prolonged “understanding phase” before explanations can be of any use (1981)—an observation that is frequently misinterpreted as pitting understanding against interpretation, typically with understanding playing the role of “what the patient wants” (and which all nice therapists give), and interpretation as “what the patient does not want but has to have”. Other patients seem unable to proceed before receiving a new perspective from the start (Mermelstein, 2002). So will any old interpretation or “re-frame” do, or does our new perspective have to be a particular one? Do our pills have to conform to some criterion supplied by the patient or to some general principles of psychology? If the patient won’t take her medicine of explanation, will a spoon full of empathy make the explanation go down?

Dissolve one tablet, (not too) slowly in the mouth, for 6-8 sessions

For CBT, the introduction of too many pills to the treatment is to be avoided. Our CBT colleagues would advise us that for treatment to be successful, we must begin by explaining our model to the patient in the hope that he will “buy it” as a sensible pursuit, lest the prognosis be a little less promising. All good psychoanalysts will, of course, explain some aspects of their treatment to the novice patient, albeit to a lesser degree, but the distinction lies more in the fact that even though some of us might hope for a post-analytic self-analysis in our patients, we are not in the business of trying to teach the patient what we do in sessions, so that she can do the same between sessions. The “other person” of treatment is perhaps more central to psychoanalysis than some other psychotherapies (cf. Cuijpers, 1997). Eventually, over time, analysands come to know as much about themselves as the analyst might have known nearer to the start of treatment, and although the pill of CBT might be soluble in the saliva of commonsense and near-immediate transparency, as analysts we probably ask more of our patients in the way of an initial period of pill-taking, and perhaps even a corresponding degree of faith.

Dissolve one tablet, five times a week for 50-minutes, for many, many years

In psychoanalysis, the centrality of a focus on unconscious processes leads us routinely to speak to the patient of various “pills”. We might interpret erotic transference when the patient becomes self-deprecating, we might interpret aggression when the patient begins to cry. Having jettisoned the couch or the frequency of sessions as fail-safe markers of psychoanalysis, there remains some confusion within our profession about what could identify psychoanalysis as a unique treatment in a post-modern, or post-Cartesian, (or post-what-have-you) world. What are our unique pills? Amid this confusion, most of us would probably still be happy to include something about the unconscious and the transference in our favourite definition of analysis, but would that in itself suffice? Goldberg is certainly one who is happy to base a definition on the unconscious and the transference, having recently offered us a definition of psychoanalysis as “the scientific study of understanding”, which is identified by its hermeneutic cycle (Goldberg, 2004). This definition gives a kind of clarity to the search for the distinctiveness of psychoanalysis—distinct from other psychotherapies, from intersubjectivity, from relational approaches, and from other social psychologies—that we have not seen in our profession for decades. Such a definition simultaneously highlights the folly of trying to use any extra-analytic (i.e., non-analytic) data (e.g., those of the neurosciences) to support analytic contentions. This folly is obvious to most other scientists, but has somehow remained remarkably seductive to psychoanalysts. Goldberg’s vision includes a particular kind of psychoanalytic pill, which shows that we need not travel beyond the borders of our own activity to find the data of confirmation of our theories.

Goldberg demonstrates convincingly how interpretation is both i) essential to psychoanalysis, because, epistemologically speaking, it is never optional for any scientific activity, and ii) unique to psychoanalysis when used to make something formerly unconscious known to the patient. This is the definition of a “specific factor” par excellence, and one that might frighten-off some analysts and non-analysts alike. Many of our colleagues...
shy away from this simple position of the analyst knowing something about the patient that
the patient does not know, and interpreting it. While it might formerly have been humorous to
fear such a situation, (cf. Basil Fawlty’s reaction to a psychiatrist staying in his hotel), many
psychologists eschew this position on the grounds that it foolishly assigns the analyst an
impossible ‘privileged’ knowledge and position, beyond that of the patient, which is argued by
some to be philosophically untenable or at least unpalatable. With unique clarity and flair,
Goldberg picks-up themes from the philosophy of Heidegger to demonstrate—in a manner I
could not replicate in the present context—i) the indispensable presence of interpretation in
any true scientific observation, and ii) that the familiar criticism of psychoanalysis being
unscientific because the analyst knows certain things about the patient in advance, has
indeed missed the point. It is not the fore-knowing itself that should be a cause for concern
(cf. Heidegger’s “fore-having”, “fore-sight”, “foreconception”, p33). While many things might
be interpreted in many kinds of therapy, those interpretations that do not lead to
understanding are not to be considered psychoanalytic. “[P]sychoanalysis… demands both
understanding another as well as the other feeling understood” (p49). “…[I]nterpretations of
whatever sort that merely make a claim about one or another contents of the “unconscious”
without the achievement of furthering understanding fall outside of the arena of activity that
psychoanalysis attends to since they are distinct from true understanding”. This should not
be mistaken as being a fixed religious-like proclamation of the same thing over and over in
treatment, a persistence despite any evidence to the contrary. Rather, “the sequence of
moving from one interpretation to another is a sign that we do indeed understand, since the
world is never static and demands constant interpretive activity” (p68). And the achievement
of understanding by an interpretation is a criterion that requires nothing outside of
psychoanalysis for validation.

The unconscious is suggested by the presence of the irrational: things that the patient
cannot understand about his behaviour or experience (why do I check the locks 100 times?,
why do I treat my boyfriends progressively worse until they leave me?). The unconscious
reveals itself via the transference (why do I treat my analyst etc…), and the interpretation of
the unconscious makes the formerly irrational understandable to the patient by supplying a
missing piece of information known first to the analyst. In this way, understanding where
misunderstanding (or the irrational) was previously, is the criterion of utility and “correctness”
of a psychoanalytic interpretation. Here we can start to see the essence of (some of) the
distinction between CBT and psychoanalysis: We interpret the unconscious piece of the
puzzle to make the formerly-irrational make sense, while CBT designates the irrational as a
kind of problematic foreign body in the patient’s psyche, which (whether removed or allowed
to fall into disuse) must be ultimately abandoned in the process of cognitive restructuring, in
favour of other, rational replacements or detours. Two different pills indeed.

Conclusion

Somewhere beyond merely adopting a duplicate of the patient’s understanding of his
problem is a place where a therapist can offer something unique to the discussion. Too
strong a distaste for playing the “expert” or the tendency to want to abdicate, could make us
run the risk of failing to give the patient the very least he deserves (cf. Sullivan). Embracing
the fore-knowledge of an expert might begin to flirt with our becoming unscientifically insular
in our vision, unless we can use something in the patient’s experience of treatment to verify
our theoretically-informed judgments. That the patient ultimately arrives at understanding
ensures that the pill of psychoanalysis is not simply the foreign-body it might, at first, appear
to be.

REFERENCES
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