

## Document 2

### GRADUATION CRITERIA FRAMEWORKS

Developed and Implemented at the Psychoanalytic Association of New York (formerly the Institute for Psychoanalytic Education affiliated with NYU School of Medicine)

*Excerpted from the institute's Candidate Manual 2018-2019*

#### PSYCHOANALYTIC COMPETENCIES FRAMEWORK

The elements below are to be used as guidelines, not as a checklist. We are not searching for perfection. The skills are ideals that we as analysts continually strive to develop. Some of them will be competently achieved and some will not - during candidacy, by the time of graduation, and throughout one's career. The proficiencies will emerge as part of one's learning experience. As senior candidacy progresses, it is expected that enough of these skills will have been demonstrated in your clinical work, reports, and supervision that a judgment can be made about your ability to work independently, and thus to graduate.

The following categories inevitably overlap but are useful in orienting candidates, supervisors, and the Student Progression Committee (SPC) in thinking about the development of analytic skills.

#### ***1. Analytic Attitude and Stance***

- **Exercises good clinical judgment**
  - During the initial assessment when reflecting on the history, pathology, interview process, the pros and cons of analysis for any given patient with this analyst, and in integrating and balancing the influence of your previous education and training
  - In helping the patient transition from the consultation or psychotherapy into analysis
  - Throughout the analysis
- **Capacity for analytic listening**
  - Demonstrates and promotes an ongoing spirit of inquiry, curiosity and openness, and a non-judgmental attitude
  - Attends patiently and non-prejudicially with free-floating attention for meaning to emerge but not so long as to opt out or frustrate
  - Is attuned to nuances of the patient's and analyst's verbal and non-verbal communications, with an ear to latent meaning
  - Thinks flexibly and imaginatively; changes perspective; tolerates complexity and contradiction; open to being surprised
  - Focuses predominantly on the internal world of the patient
- **Dependability, steadfastness, patience, and commitment to the analytic task**
  - Sustains capacity for empathy
  - Works effectively with defenses, resistances and transferences, including when these become entrenched
  - Tolerates not knowing, ambiguity and frustration
  - Observes and respects personal and ethical boundaries

#### ***2. Self-Awareness and Self-Assessment***

- Reflects upon and makes use of one's own feelings to help understand the patient

- and interactions with the patient
- Is aware of own sensitivities and potential blind spots, and the effects of one's own style and personality on the patient
- Is aware of personal limitations in working with certain types of patients
- Contains and processes the patient's and/or one's own affective intensity along the entire spectrum of emotion from severe hostility, periods of sustained uncertainty and isolation of affect to intense longing and intimacy
- Notices and is motivated to analyze one's own mistakes and enactments, and can recover from a loss of analytic stance

### ***3. Interventional Skills***

- **Effectiveness of interventions**
  - Thinks and works analytically in establishing and maintaining the treatment frame and the patient's experience of it (e.g., use of the couch, fees, missed sessions, patient's questions)
  - Makes interventions that are experience-near, at the affectively available surface, and accurately address what is accessible to the patient
  - Demonstrates clarity, succinctness and sensitivity to the tone and timing of interventions
  - Grasps the nature of a patient's response to interventions and reflects on its meaning
  - Helps the work broaden and deepen, facilitating patients' progress in their analyses
- **Flexibility of interventions**
  - Emphasizes interpretations while also understanding the value of non-interpretive aspects of the work, such as supportive interventions
  - Considers whether working in the transference or outside the transference at given moments will further the analysis
  - Works effectively with surface and depth, defenses and wishes
  - Reflects thoughtfully upon when it will and will not be helpful to work with the patient's past

### ***4. Conceptual Skills***

- Demonstrates knowledge of theories of mental functioning without being theory bound or overly intellectualized
- Understands important analytic concepts including, but not limited to, the dynamic unconscious, dreams, defenses, central organizing fantasies, transference, countertransference, enactments, technical neutrality, reconstruction, the role of trauma, conflict vs. deficit
- Follows the flow of material within the session, as well as the macro-development of important themes and processes (e.g., shifts in the patient's transferences) over the course of the analysis
- Is developing coherent ideas about the nature of therapeutic action of psychoanalysis and its potential for profound psychological change

### ***5. Written Reports***

- Conveys the story of the analysis clearly, vividly and openly, including examples of process material that bring the work alive
- Able to convey process: what led to what in the analysis
- Conveys and reflects upon problems and struggles in the analysis as well as future challenges
- If the patient interrupts the analysis, or the analyst decides to interrupt or alter the nature of the treatment, he conveys what went on as well as what was and was not accomplished

- Reflects on the role of supervision in the work with the patient

## **6. Supervisory Process**

- Presents material candidly and lucidly
- Accepts and learns from constructive criticism
- Demonstrates a collegial relationship with the supervisor and the ability to think and work independently, beginning to find his or her own “analytic voice”
- Self-supervises, reflecting on possible mistakes or misjudgments and what in hindsight one would do differently
- Recognizes the indications for and is willing to seek supervisory input in the future

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## **IMMERSION FRAMEWORK: PHASES OF ANALYSIS**

Supervised work with a minimum of three non-psychotic adult patients is required. Of these three cases, at least two – one male and one female – have progressed beyond the opening phase. One of these must exhibit characteristics of an Early Mid-Phase and the other characteristics of an Advanced (or Deep) Mid-Phase.

The following schematic description delineates many key aspects of a developing analytic process. It is characterized most importantly by processes that focus on the analysis of transference manifestations in relation to the person of the analyst. However, this does not imply that all analyses follow a linear course; in reality few analyses are “typical” and many variations occur in successful analyses. For example, there may be sudden shifts in the balance between expressions of transference and resistance, temporary advances and/or regressions, unexpected enactments, crucial insights that are seemingly lost, and external events that impact the analysis (e.g., insurance issues, job changes, educational requirements, marriages, births, deaths, the patient’s and/or the analyst’s health, and the like). These and many other occurrences require the analyst to be flexible, patient and open to the “unexpected” with patients and with his or her responses to these situations. Furthermore, transference elements may often be effectively analyzed in relationship to significant others in the patient’s life; work with some patients may involve exploration of challenges to the frame repeatedly throughout the analysis or at later phases rather than being restricted to the opening phase. The analyst’s increasing confidence and clarity of understanding in mid-phase may alternate with periods of uncertainty or even perplexity. Furthermore, the technical emphasis of the opening phase may differ for some patients with more severe pathology.

We offer this description to candidates at IPE as an educational tool that can be useful in discussion with supervisors, SPC advisors, and continuous case instructors, as well as for personal reflection, while simultaneously recognizing that there can be controversy about what constitutes an analytic process.

### **Opening Phase**

The analyst and analysand begin to experience being with each other in this new and unusual relationship in which the patient is invited to share whatever comes to mind while (typically) lying on the couch without face to face contact with the analyst. The patient begins to learn that it is useful to share with the analyst not only symptoms, but a variety of data, such as childhood experiences, what is going on in the here-and-now, dreams, slips of the tongue, visual images, bodily sensations, and thoughts and feelings about the analyst. As the patient starts to appreciate that meanings attached to these experiences may be inter-connected, he or she also begins to understand how to work with this material. A major aspect of analytic work in this beginning period involves helping the patient to become aware of his or her resistances, and to begin to realize the power of these manifestations of defense in order to become attentive to and understand the ways they may appear, as well as the conscious and unconscious effects they are

the ways they may appear, as well as the conscious and unconscious affects they are intended to avert. In other words, the patient begins to become aware of the existence of internal conflict. These resistances are often expressed in challenges to the frame in contexts such as establishing analytic frequency, the fee, free associating, using the couch, and the handling of missed sessions and personal questions about the analyst. In addition, both analyst and patient begin to recognize some elements of their transference and countertransference reactions, and the patient becomes increasingly aware that there is a dynamic unconscious. The time period necessary for this beginning work varies widely for different patients; in rare instances it may take months, but more often one to two or three years, and even longer with some patients.

### **Early Mid-Phase**

The analysis and analyst become more and more central emotionally to the patient, and the analysis as a structure and process can become increasingly stable. An initial focus on reporting of symptoms begins to give way to a greater emphasis on the meanings of symptoms and on character. Transference-countertransference manifestations are gradually clearer as more and more derivatives offer evidence that support the analyst's interpretations, especially as resistances are worked with analytically. They may be experienced in fantasies and enactments expressed verbally or in action. These provide useful material for both patient and analyst to explore, and result in both the patient's fuller awareness of transference and the analyst's greater awareness of both transference and countertransference. The analyst often experiences more confidence in understanding the analysand's psychology and in his or her interventions. This, too, is subject to vicissitudes and challenges to certainty – as evidence may emerge that requires revision of previous interpretations. Some modifications are often observable in the patient's defensive style and ability to reflect on internal states and motivations – including the patient's reflecting upon the internal state of the analyst - as well as resistances to doing so. As this phase develops, with its deepening of the transference (and the patient's fuller appreciation of it), the analyst's interventions may place a greater emphasis on the here-and-now of the patient's mind within the session and less on the external life of the patient.

### **Advanced (or Deep) Mid-Phase**

Typically, the analysis and analyst have become of central importance to the patient. The patient-analyst pair engages in increasingly productive analysis of transference-countertransference patterns that have become more clear, interpretable, and workable, as well as reconstruction of the influence of childhood experiences, including traumatic events that have shaped childhood and current experience. Interpretations of specific content in these areas may become more prominent relative to work on defense and resistance. The patient's productions are usually more coherent, so that links between transference and extra-transference, and past and present become more evident and accessible to the patient and analyst. This may contribute to the analyst's increasing pleasure and/or freedom to interpret. Core conflicts are worked on over and over again in an affectively vivid way in the here-and-now and there-and-then, as various facets of these conflicts become manifest in the patient's life as well as in the analytic situation; the patient can also better appreciate connections between the two. Some significant changes in the nature of the relationship with the analyst, and/or in the patient's life outside the analysis, usually take place. The patient also evidences greater ability to engage in self-analysis; s/he notices new resistances as well as the old defensive patterns and some increased flexibility to use a greater variety of defenses, and a more developed and differentiated affective life.

### **Termination**

The patient has achieved a significant capacity for self-analysis and an appreciation of the conflicts that underlie manifest complaints, although the latter may not always remain conscious. By this time the patient has a fuller, more complex, and nuanced view of the personal narrative presented at the beginning of the analysis, and there is significant

improvement in the problems that brought him or her into treatment. Core conflicts and complaints are inevitably revived, although usually -- but not invariably -- with less intensity, as termination is anticipated. This period offers an opportunity to further elaborate these core conflicts in the context of the impending loss of the analyst as a representative of old object relationships, as well as a real person and a daily presence. This work is done with a greater sense of independence from the analyst and of self-reliance to do analytic work. Emotional appreciation of the reality and meanings of loss is inevitable (and necessary for an internalization of the analytic relationship and process to become structured). Themes of loss and mourning are common, as the patient relinquishes idealized fantasies that pertain to the analyst and to him or herself, even after the completion of a successful analysis. The analyst also deals with the loss of the patient and his/her countertransference responses that often mirror the patient's experiences of object loss. Both parties develop an awareness of the limitations of the treatment and an appreciation of what it has accomplished.