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THAT WAS THEN, THIS IS NOW: PSYCHOANALYTIC PSYCHOTHERAPY FOR THE REST OF US

Abstract. Psychoanalysis has an image problem. The dominant narrative in the mental health professions and in society is that psychoanalysis is outmoded, discredited, and debunked. What most people know of it are pejorative stereotypes and caricatures dating to the horse and buggy era. The stereotypes are fueled by misinformation from external sources, including managed care companies and proponents of other therapies, who often treat psychoanalysis as a foil and whipping boy. But psychoanalysis also bears responsibility. Historically, psychoanalytic communities have been insular and inward facing. People who might otherwise be receptive to psychoanalytic approaches encounter impenetrable jargon and confusing infighting between rival theoretical schools. This article provides an accessible, jargon free, nonpartizan introduction to psychoanalytic thinking and therapy for students, clinicians trained in other approaches, and the public. It may be helpful to psychoanalytic colleagues who struggle to communicate to others just what it is that we do.

Keywords: psychoanalysis, psychoanalytic therapy, psychoanalytic education, public perceptions

It was a surprise when Philip Bromberg emailed me one day, out of the blue. We had never met. I did not know he had ever heard of me or my work, and he was unsure I knew of his—although of course I did. Philip had just watched an interview I did with author and journalist Oliver Burkeman (https://www.youtube.com/watch?v=pUxkgEeqcXg). I discussed psychoanalytic therapy in ways that made

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it accessible to the public and I debunked some all-too-common myths.

Philip said two things that stayed with me. He wrote, "I am so grateful to you for being someone in my life whom I *feel* as a companion even though we have never met." And, "You are the real deal." It was one of my proudest moments.

It turned out Philip was deeply concerned, like me, about public perceptions and misperceptions of psychoanalysis, outside our own echo chambers (Shedler, 2010). What most people today know of psychoanalysis are pejorative stereotypes and caricatures dating, literally, to the horse and buggy era. If they took a college psychology course, they would have encountered concepts from the turn of the 20th century—like id, ego, and superego, and fixations, and penis envy—presented as objects of ridicule. They would have been told psychoanalysis is unscientific and debunked. They would have no clue what contemporary psychoanalysis is, let alone how it could be relevant to their lives.

Aspiring to make contemporary psychoanalytic thought more accessible, I drafted a few chapters of what may one day become a book. My aim was to provide a jargon-free, nonpartizan introduction for trainees and clinical colleagues trained in other therapy approaches. The title is a double entendre. "That Was Then, This is Now" alludes to a central aim of psychoanalytic therapy—to help free people from the bonds of past experience in order to live more fully and freely in the present. It also alludes to the sea changes in psychoanalytic theory and practice that have occurred over the past decades.

What follows is a chapter from this work in progress, offered in honor of Philip and in the hope it may be useful to psychoanalytic colleagues trying to communicate to others just what it is that we do.[1]

Foundations

If psychoanalysis is not a theory about id, ego and superego, or fixations, or repressed memories, what *is* it about? The following ideas are

[1] The full document is available at jonathanshedler.com/writings. The interview that prompted Philip Bromberg to contact me ("Interview with author-journalist Oliver-Burkeman") is available online in both video and audio format. Links to both can be found at jonathanshedler.com

central to most psychoanalytic clinicians. They are intertwined and overlapping. I present them separately only for didactic convenience.

Unconscious Mental Life

We do not fully know our hearts and minds, and many important things take place outside awareness. This observation is no longer controversial to anyone, even the most hard-nosed empiricist. Research in cognitive science has shown repeatedly that much thinking and feeling goes on outside conscious awareness (e.g., Bargh & Barndollar, 1996; Kahneman, 2011; Nisbett & Wilson, 1977; Weinberger & Stoycheva, 2019; Westen, 1998; Wilson et al., 2000). Usually, cognitive scientists do not use the word "unconscious" but refer instead to "implicit" mental processes, "procedural" memory, and so on. The terminology is not important. What matters is the concept—crucial memory, perceptual, judgmental, affective, and motivational processes are not consciously accessible. Psychoanalytic discussions of unconscious mental life do, however, emphasize something cognitive scientists tend not to emphasize: It is not just that we do not fully know our own minds, but there are things we seem not to *want* to know. There are things that are threatening or dissonant or make us feel vulnerable in some way, so we look away.

I came across a poignant example early in my career. I was interviewing participants in a research project on personality development and my job was to learn as much as I could about each participant's personal history. In general, they were easy interviews to conduct. Most people, with a little encouragement, enjoy talking about themselves to someone respectful, sympathetic, genuinely interested in what they have to say, and sworn to confidentiality. But one interview was puzzlingly tedious. Although the interviewee, whom I will call "Jill," was attractive and intelligent, and although she seemed to answer my questions cheerfully and cooperatively, I did not feel engaged at all. Slowly, I began to recognize that Jill's answers to my questions amounted to a string of generalities and platitudes. I could not get a sense of Jill or the people important to her.

Our conversation went something like this:

> Can you tell me some more about your sister? What sort of person is she and what sort of relationship have you had?

She is neurotic.

In what way is she neurotic?

You know, just neurotic in the usual way.

I'm not sure what 'the usual way' is. Can you help me understand how she is neurotic?

You're a psychologist, you know what I mean by "neurotic." That's the best word to describe her. I'm sure you see a lot of people like her.

After much questioning, Jill eventually told me her sister was spiteful and said mean things about their father in order to embarrass him. Jill described her father as a kind, caring man who had done nothing to deserve such an ungrateful, hostile daughter. I had to ask Jill repeatedly for a specific example of what her sister said. Eventually, Jill described an incident that occurred when she was five and her sister was seven. The family was at the beach and her sister was being "bitchy and provocative." Her kind, caring father lost his temper and held his seven-year-old daughter underwater until she nearly drowned. As Jill told this story, her emphasis was entirely on how provocative her sister had been. She seemed unaware she had just described child abuse. Jill told me other examples of how her sister was "neurotic," all of which ended with her father violently out of control.

I did not have the sense Jill was trying to mislead me or hide the truth. What was striking was that Jill seemed unaware there were any conclusions to draw from these events except that her sister was neurotic. This is a stark example of the kind of thing I mean when I say there are things we seem not to want to know.

Note that this vignette has nothing to do with "repressed memories," which get attention in the media—and have virtually nothing to do with contemporary psychoanalytic therapy. The goal of psychoanalytic treatment is not to uncover repressed memories, nor has it been since the early 1900s. It is to expand freedom and choice by helping people become more mindful of their experience in the here and now. To my knowledge, *none* of the therapists involved in public controversies about "false memories" have been psychoanalysts.

Jill's difficulty was not that she did not remember. On the contrary, her memories were crystal clear. Rather, Jill had fixed on one interpretation of events and had not allowed herself to consider others. This

rigidly held view doubtless once served a purpose for Jill. For example, it may have allowed her, as a small child, to preserve a desperately needed sense of safety and security in a family that was terrifyingly unsafe. This touches on an important concept in psychoanalytic psychotherapy: Most psychological difficulties were once adaptive solutions to life challenges. They may have been costly solutions, but they were solutions nevertheless. Difficulties arise when the old solutions no longer work or become self-defeating, but we continue to apply them anyway.

The Mind in Conflict

Another central recognition is that humans can be of two (or more) minds about things. We can have loving feelings and hateful feelings toward the same person, we can desire something and also fear it, and we can desire things that are mutually contradictory. There is nothing mysterious in the recognition that people have complex and often contradictory feelings and motives. Poets, writers, and reflective people in general have always known this. Psychoanalysis has contributed a vocabulary with which to talk about inner contradiction, and techniques for working with contradictions in ways that can help alleviate suffering. To paraphrase F. Scott Fitzgerald, wisdom is the ability to hold two contradictory ideas in mind at the same time and still continue to function. Psychoanalytic psychotherapy seeks to cultivate this form of wisdom.

The terms *ambivalence* and *conflict* refer to inner contradiction. *Conflict* in this context refers not to opposition between people, but to contradiction or dissonance within our own minds. We may seek to resolve contradiction by disavowing one or another aspect of our feelings—that is, excluding it from conscious awareness—but the disavowed feelings have a way of "leaking out" all the same. One result is that we may work at cross-purposes with ourselves. An analogy I sometimes use with patients is driving a car with one foot on the gas and one foot on the brake. We may eventually get somewhere, but not without a lot of unnecessary friction and wear and tear.

Many people experience conflict around intimacy. We all seem to know someone who desires an intimate relationship but repeatedly develops attractions to people who are unavailable. These attractions may represent an unconscious compromise between a desire for

closeness and fear of dependency. A friend of mine always seemed to become romantically interested in more than one person at a time. He agonized about which person was right for him, but his simultaneous involvement with multiple people ensured he did not develop a deeper relationship with any.

One of my first patients could not allow himself to recognize or acknowledge his desire for caring and nurturing. He equated these desires with weakness and chose women who were cold, detached, and even hostile. These women did not stir up his discomfiting longings for nurturing. Not surprisingly, he was dissatisfied with his intimate relationships. Through therapy, he came to recognize his desire for emotional warmth. Only then was he able to choose a loving and supportive partner.

When both members of a couple struggle with conflict around intimacy, we often see a dance in which the partners draw together and pull apart in an unending cycle. As one pursues, the other withdraws. Deborah Luepnitz (2002) has written a moving book on psychoanalytic therapy emphasizing just this dilemma, titled *Schopenhauer's Porcupines.* The title refers to a story told by Schopenhauer about porcupines trying to keep warm on a cold night. Seeking warmth, they huddle together, but when they do they prick each other with their quills. They are forced to move apart but soon find themselves cold and needing warmth. They draw together again, prick each other again, and the cycle begins anew.[2]

Conflicts involving anger are also commonplace. Some people, especially those with a certain kind of depressive personality, seem unable to acknowledge or express anger toward others but instead treat themselves in punitive and self-destructive ways. In his first-person account of depression, *Darkness Visible: A Memoir of Madness*, William Styron described winning a $25,000 literary prize and promptly losing the check. He realized afterward the accident of losing the check was not so accidental but reflected his deep self-criticism and feeling of unworthiness.

There are many reasons people disavow angry feelings. We may fear retribution or retaliation; we may fear our anger will hurt someone

[2] For readers who may have been taught psychoanalytic approaches are relevant only to the privileged or wealthy, Luepnitz's book also provides moving examples of psychoanalytic therapy with diverse and marginalized patients.

we love; we may fear it will lead to rejection or abandonment; the angry feelings may be inconsistent with our self-image as a loving person; we may feel guilt or shame for having hostile feelings toward someone who has cared for us, and so on. I once treated a man whose parents were Holocaust survivors, who sacrificed greatly so their son could have a better life. They worked long hours at menial jobs so he could go to medical school and become a prosperous person. Under the circumstances, anger toward either parent would have brought crushing guilt. My patient could not allow himself angry feelings toward either parent, but he treated his friends and colleagues—and *himself*—quite badly. It took considerable work before he could recognize his angry feelings and recognize love and gratitude can coexist with anger and resentment. He came to understand that anger toward his parents did not diminish his love for them, his grief for their suffering, or his gratitude for their sacrifices.

Some people express disavowed anger through passive-aggressive behavior (yet another psychoanalytic term that has been assimilated into the broader vocabulary of therapy). For example, someone who regularly burns the family dinner may be expressing, in the same act, their devotion to their family and their resentment. Preparing the dinner expresses love and devotion; making it unpalatable expresses anger. My mother often expressed anger passive-aggressively by making people wait for her. She'd arrange to pick me up at the airport when I came home from college, but she'd show up two hours late. In her mind, meeting me at the airport was an act of devotion, consistent with her view of herself as a loving, self-sacrificing mother. Being late was circumstantial. Unfortunately, the same "circumstances" arose time and again. The sources of my mother's resentment were no doubt manifold, but I believe one source of resentment was that I had gone away in the first place.

A charming example of ambivalence occurred as I was editing this manuscript, working on my laptop computer at a sidewalk café. A fifteen-month-old girl toddled over from an adjacent table, picked up a pretty leaf from the ground, and offered it to me with a huge smile. Just as I said "thank you" and reached to take it, she snatched it away with obvious delight. I encounter similar behavior in adults, but it is generally less charming.

A last and more obviously "clinical" example of conflict can be seen in certain patients who suffer from bulimia. On the one hand, binge

eating may express a desperate wish to devour everything, perhaps to fill an inner void. The symptom seems to say, "I am so needy that I can never be filled." Purging expresses the other side of the conflict and seems to say, "I have no needs. I am in control and require nothing." Of course, things are generally more complicated, and inner (or intrapsychic) conflict can have many sides, not just two. The example illustrates just two of many possible meanings that may underlie bingeing and purging. Psychological symptoms often have multiple causes and serve multiple purposes. We use the terms *overdetermination* and *multiple function* to describe this multiplicity of meanings. We will revisit the terms shortly.

Psychoanalytic therapists were the first to explicitly address the role of inner conflict or contradiction in creating psychological difficulties, but it is noteworthy that every therapy tradition addresses conflict in one way or another. Cognitive therapists may speak of contradictory beliefs or schemas, behaviorists may speak of approach/avoidance conflict or responsiveness to short-term versus long-term reinforcers, humanistic therapists may speak of competing value systems, and systems-oriented theorists may refer to role conflict. There is universal recognition that inner dissonance is part of the human condition.

Cognitive scientist Daniel Kahneman won the Nobel Prize in Economics for empirical research describing competing cognitive decision processes which he called "System 1" and "System 2" (Kahneman, 2003, 2011). System 1 works intuitively and automatically and is relatively unresponsive to new information and changing circumstances. Its operations "are typically fast, automatic, effortless, associative, *implicit (not available to introspection)*, and often emotionally charged" (Kahneman, 2003, p. 698, emphasis added). In contrast, "the operations of System 2 are slower, serial, effortful, more likely to be consciously monitored and deliberately controlled" (Kahneman, 2003, p. 698). These cognitive systems work in tandem and often produce disparate results. Such contradictions may be rooted in the structure of the brain, with the different decision systems reflecting activity of the basal ganglia and prefrontal cortex, respectively.

These findings from cognitive science, based on controlled experiments, have striking parallels with Freud's descriptions, many decades ago, of conscious and unconscious mental processes. *Far from discrediting core psychoanalytic assumptions, research in cognitive*

science and neuroscience has provided an empirical foundation for many of those assumptions. It is also helping psychoanalytic thinkers refine their understanding of mental processes and effective intervention (e.g., Gabbard & Westen, 2003; Weinberger & Stoycheva, 2019; Westen et al., 2002, 2002).

The Past Lives on in the Present

Through our earliest experiences, we learn certain templates or scripts about how the world works (a cognitive therapist would call them schemas). We learn, for example, what to expect of others, how to behave in relationships, how to elicit caring and attention, how to act when someone is angry with us, how to express ourselves when we are angry, how to make people proud of us, what it feels like to succeed, what it feels like to fail, what it means to love, and on and on. We continue to apply these templates or scripts to new situations as we proceed through life, often when they no longer apply. *We view the present through the lens of past experience*—and therefore tend to repeat and recreate aspects of the past. In the words of William Wordsworth, the child is father to the man.

Examples of how we recreate the past abound. A little girl's father is emotionally distant. As a result, her early experiences of love come packaged with a subtle sense of emotional deprivation. In adulthood she finds herself drawn to men who are emotionally unresponsive, and the men who are emotionally available do not interest or excite her. She may recreate this pattern in therapy. When her male therapist seems distracted or bored, she perceives him as powerful and important. When he seems caring and attentive, she perceives him as bland, boring, and of little use to her.

Consider a child who receives her mother's undivided attention only when she is physically ill. At these times, her mother comforts and dotes on her. In adult life, she develops physical symptoms when she feels neglected by her husband—an unconscious effort to elicit his loving attention. (Unfortunately, her husband does not respond with doting attention, leaving her feeling confused and betrayed in ways she cannot begin to put into words.) In therapy, she talks about her physical symptoms and does not seem to have language for feelings. She assumes her therapist is interested primarily in her aches and pains

and seems confused by the therapist's invitation to talk about her emotional life.

Another person is a victim of childhood physical and sexual abuse. The *dramatis personae* in her life are abusers, victims, and rescuers. In adulthood, she recreates these role relationships by getting into situations in which she feels betrayed and victimized, looks for rescuers to extricate her, and then recreates the roles of victim and abuser with her would-be rescuer. In therapy, she initially idealizes her therapist and treats him as a savior. The therapist responds to the patient's idealization and intense need by scheduling extra appointments, allowing sessions to run overtime, accepting late night phone calls, and reluctantly acquiescing to her demands for hugs at the end of therapy sessions. Eventually the therapist feels overwhelmed and depleted and attempts to reestablish limits. The patient then feels abandoned, betrayed, and enraged. She files an ethics complaint against the therapist, pointedly noting his lack of professional boundaries (thereby becoming the abuser and making a victim of the therapist) and finds another naive therapist to rescue her from the harm done by the first. This scenario may sound extreme, but the seasoned therapist will recognize a familiar pattern (e.g., Davies & Frawley, 1992; Gabbard et al., 1992). It is a pattern characteristic of certain patients we describe as having borderline personality organization.

It is impossible *not* to perceive and interpret events through the lenses of past experience. There is simply no other way to function. Past experience contextualizes present day experience and shapes our perceptions, interpretations, and reactions. A person who felt loved, valued, and nurtured in childhood experiences the death of a spouse. They experience profound grief, go through a period of mourning, but eventually go on to love again. Another person, who experienced their childhood as a string of failures, rejections, and losses, also experiences the death of a spouse. For them, the loss may become a recapitulation of earlier losses and proof that their efforts in life must come to naught. They sink into a bitter, angry depression and do not recover. In both cases, the "objective" external experience of loss is the same, but the psychological meanings of the event are very different.

Every school of therapy addresses the impact of the past on the present. Cognitive therapists may discuss the assimilation of new experiences into existing schemas, family systems therapists may note

repetition of family dynamics across generations, and behaviorists may speak of learning history and stimulus generalization. *The goal of psychoanalytic psychotherapy is to loosen the bonds of past experience to create new life possibilities.*

Transference

A person starting therapy is entering an unfamiliar situation and a new relationship and necessarily applies their previously formed templates, scripts, or schemas to organize their perceptions of this new person—the therapist—and make sense of the new situation. There is no alternative other than to view this new relationship through the lens of past relationships; it is not a matter of choice. Thus, different patients show dazzlingly different reactions to the same therapist.

I begin therapy with all new patients in much the same way. I greet the patient, offer them a seat, and invite them to tell me why they have come. But I am *not* the same person in the eyes of my patients. Some see me as a benevolent authority who will advise and comfort them, some see me as an omniscient being who will instantly know their innermost secrets, some see me as a rival or competitor to impress or defeat, some see me as an incompetent bungler, some see me as a dangerous adversary, some see me as a disapproving parent to appease, some see me as sexy and alluring, some as cold and unresponsive, and on and on. These and a thousand other configurations emerge as therapy unfolds. Anyone who has practiced therapy for any length of time cannot help but be struck by the diversity of reactions we elicit from our patients, and by how far our patients' perceptions can diverge from our self-perceptions, and from the perceptions of others who know us in other contexts.

(The opposite is also true and often far more disconcerting. Some patients seem to have an uncanny sixth sense that enables them to home in on our very real limitations, vulnerabilities, and insecurities with laser-like precision. But that is a topic for another time.)

When I was in graduate school, a friend of mine began therapy with a man whose last name sounded something like "Hiller." In the eyes of virtually everyone, Dr. Hiller was a kind and gentle man. For a significant period in her therapy, however, my friend perceived him as an aggressive tormenter and referred to him, only half-jokingly, as "Hitler." My friend's perception changed over time, but I

believe it was important for her to experience him this way and essential that her therapist was able to tolerate this perception. Instead of trying to convince her otherwise, he allowed her to have her own perception and patiently explored the thoughts, feelings, and memories behind it.

The term *transference* refers specifically to the activation of preexisting expectations, templates, scripts, fears, and desires in the context of the therapy relationship, with the patient viewing the therapist through the lenses of early important relationships. In psychoanalytic psychotherapy, our patients' perceptions of us are not incidental to treatment and they are not interferences or distractions from the work. They are at the heart of therapy. *It is specifically because old patterns, scripts, expectations, desires, schemas (call them what you will) become active and "alive" in the therapy sessions that we are able to help patients examine, understand, and rework them.*

Not long ago, I treated a male patient whose alcoholic (and probably bipolar) father had abused him emotionally and physically. His father had castigated him, shamed him, and beat him with little provocation. It was one thing for my patient to tell me he viewed people with distrust and suspicion. It was another when this relationship template came alive in treatment, and he began responding to *me* as if I were an unpredictable, angry adversary. Consciously, he viewed me as an ally who had his welfare at heart, and he was paying me good money for my help. At the same time, he seemed to do everything in his power to "protect" himself from me by shutting me out and fending me off, acting as though I would use whatever he told me as a weapon to hurt him. He responded this way automatically and reflexively; his responses were so ingrained that he did not recognize them as at all out of the ordinary.

I did not regard my patient's attitude toward me as an obstacle to therapy. On the contrary, reliving and reworking this relationship pattern was central to his recovery. Repeatedly, I would point out—as gently as I could manage—that he was responding to me as if I were a dangerous adversary. I would say, "When you turned to your father for help, he humiliated you. Given your experience, it's understandable you would expect the same treatment from me." Or, "You are letting me know our work means nothing to you and you couldn't care less if you never saw me again. Perhaps you are convinced I will

disappoint and hurt you and are trying to protect yourself by rejecting me first."

Over time he came to understand—not in an intellectual way, but in a way that truly sunk in emotionally—that he was treating me (and other important people in his life) in ways that were more applicable to another person in another time and another place. Gradually, he began to call into question his expectations, reactions, and interpretations of events. Additionally, I weathered his suspicions, accusations, and rages without retaliating and without withdrawing, at least most of the time. Our relationship therefore served as a template for a new and different kind of relationship. Over time, he came to view relationships through different lenses. The world began to feel less dangerous, and his relationships became more fulfilling.

In psychoanalytic therapy, we deliberately arrange things so our patients' interpersonal expectations, templates, or schemas are cast in high relief in the treatment. In other words, we do our best to allow transferences to unfold and become palpable. It is the hallmark of psychoanalytic therapy that we *utilize* the transference (and also the countertransference—that is, our own emotional reactions to our patients) as a means of understanding the patient and effecting change. *It is a central premise of psychoanalytic psychotherapy that problematic relationship patterns reemerge in the relationship with the therapist*. This is how we come to know our patients and where we ultimately target our interventions.

Empirical research shows that the most effective therapists are those who recognize transference and utilize it therapeutically, regardless of the kind of therapy they *think* they are practicing. Enrico Jones and his colleagues (Ablon & Jones, 1998; Jones & Pulos, 1993) studied recordings of psychotherapy sessions from the NIMH *Treatment of Depression Collaborative Research Program*, rating the sessions on 100 variables that assessed the kinds of interventions the therapists employed. The therapists with the best outcomes were those who consistently noted their patient's emotional responses to *them* in the therapy sessions and drew links between these responses and their responses to other important people in their lives. This was true even for therapists providing manualized cognitive-behavioral therapy (CBT), which did not officially acknowledge transference as a

mechanism of change. The therapists were effective because they *departed* from the interventions specified in the treatment manual.

It is fair to ask whether something unique about therapy evokes strong transference reactions or whether transference is ubiquitous in all relationships. The answer is both. We view all relationships through the lenses of early important relationships. At the same time, therapy can elicit especially raw feelings. This is because therapy is not just another relationship. It is an ongoing relationship between a person who may be in desperate need and a person who is there to help. The situation inherently stirs up powerful longings and dependency. In fact, the therapy situation psychologically recapitulates our relationships with our earliest caregivers and therefore exerts an especially regressive pull. The therapist becomes a magnet for unresolved desires and fears. Therapy can evoke all of the untamed feelings we once experienced toward our early caregivers, including expectations of omnipotence, powerful yearnings, love, and hate. Woe to the therapist who fails to recognize the power inherent in the therapist role.

Other aspects of the therapy situation also exert a regressive pull. More frequent meetings intensify transference feelings. (This is one reason psychoanalytic therapy can accomplish more when meetings occur several times per week. By the same token, some more troubled patients cannot tolerate the intensity and do better in once or twice per week therapy.) The fact that communication in therapy is largely one-sided also encourages regressive fantasies. In ordinary social interaction, people take turns sharing information, but in therapy, the patient does most of the talking. The therapist learns a great deal about the patient's life, but the patient may know little about the therapist's life. In the absence of information, people tend to fill in the gaps with their own desires, fears, and expectations (much as the shapes we perceive in Rorschach cards reveal as much about us as they do about the actual inkblots).

Many schools of therapy are now converging on the recognition that people recreate problematic relationship patterns in their relationship with their therapists and this can be used for therapeutic ends. Cognitive therapists are increasingly attending to patients' emotional reactions to the therapist rather than treating them as distractions from the work (e.g., Safran, 1998; Safran & Segal, 1990), and I was a bit surprised when I heard my students who identify as "radical behaviorists"

discussing something they called a CRB, an acronym for Clinically Relevant Behavior. A CRB is defined as an instance of symptomatic behavior expressed in the therapy session toward the therapist—in other words, *transference*. From the point of view of radical behaviorism, effective intervention involves helping patients recognize CRBs and develop new ways of relating (Kohlenberg & Tsai, 1991). Such convergences among schools of therapy are not surprising. It makes sense that thoughtful professionals, struggling to understand the same psychological dilemmas, would eventually converge on similar ideas. However, I confess I find it disconcerting when adherents of other therapy traditions invent new names for phenomena that psychoanalytic practitioners have recognized for generations and proceed to discuss them as if they were new discoveries.

I would be remiss in concluding this section on transference without acknowledging newer, postmodern movements in psychoanalytic thought, which add a corrective to earlier, mechanistic, and long-discredited views of transference as something created solely by the patient. In the hands of a dogmatic, authoritarian, or unreflective therapist (attitudes that have no place in any form of psychotherapy), the concept of transference can be misused. In the worst-case scenario, it can become a way of blaming the patient for the therapist's failings. For example, if a therapist treats a patient callously, it would be a travesty of psychoanalytic practice to interpret the patient's hurt and anger as a pathological "transference" distortion. Contemporary psychoanalysts who advocate relational and intersubjective approaches remind us that our patient's responses do not occur in a vacuum. Patient and therapist mutually influence one another in complexly reciprocal ways and continually co-construct or co-create their experience together.

There have been tempests in the psychoanalytic literature around this issue, but they need not concern us here. It seems undeniable that patients bring their personal histories into the therapy relationship, that early relationship templates become reactivated and replayed, and unresolved hurts and longings get directed toward the therapist. It also seems undeniable that the therapist shapes the therapeutic interaction and influences which templates come into play and how. It is not only patients but also therapists who bring their pasts into the consulting room.

Defense

Once we recognize there are things we prefer not to know, we find ourselves thinking about how it is that we avoid knowing. *Anything* a person does that serves to distract their attention from something unsettling or dissonant can be said to serve a defensive function. There is nothing at all mysterious about defensive processes. Defense is as simple as not noticing something, not thinking about something, not putting two and two together, or simply distracting ourselves with something else. Psychoanalyst Herbert Schlesinger (2003) described defense in the context of systems theory. Both biological and psychological systems regulate themselves to maintain equilibrium or homeostasis (for example, biological regulatory processes work to keep our body temperature near 98.6° Fahrenheit despite large variations in outside temperature). When something is sufficiently dissonant with our habitual ways of thinking, feeling, and perceiving that it would disrupt psychological equilibrium, we tend to avoid, deny, disregard, minimize, or otherwise disavow it. Family systems therapists work to disrupt homeostatic processes that maintain dysfunctional family patterns, expecting the system will reorganize in a more adaptive way. Analogously, psychoanalytic therapists work to disrupt homeostatic processes that maintain the dysfunctional patterns we repeat.

Older psychoanalytic writings refer to *repression* of thoughts and feelings, but I no longer find the term particularly helpful, and it is my impression other contemporary psychoanalytic writers also struggle for better words. I believe the word contributes to mystification of something simple, ordinary, and commonplace. Bruno Bettelheim (1982) has argued that the word "repress" may be a poor translation of the German word Freud used and has suggested "disavow" as a more helpful translation. My dictionary's definition of "disavow" is "to disclaim knowledge of, responsibility for, or association with; disown; repudiate."

Disavowal of experience is commonplace. Jill, whom I used as an example in the section on Unconscious Mental Life, disavowed knowledge that her father had been physically violent and abusive. She defended against this recognition by keeping thoughts about her family members at the level of generalities and avoiding specifics. People often think and speak in generalities when attention to specifics would call into question cherished beliefs. Jill did not make a conscious

decision to think and speak in generalities. She did it habitually and reflexively. It had become a part of her character. Later in our interview, it began to dawn on Jill that her father had been violently out of control. Even with the ugly truth out in the open, Jill sought to preserve psychological homeostasis by downplaying its significance. Noting my grave reaction when she told me her father had nearly drowned her sister, Jill quickly sought to reassure herself and me that the event held no special significance. Emphasizing again how ill-behaved her sister had been, she added, "Anyone's father would have done that, right?"

Earlier, I mentioned a patient who had difficulty recognizing and acknowledging his desire for caring and nurturing, who repeatedly chose cold, detached women. His choice of partners served a defensive function because it helped him avoid the difficult feelings stirred up in him by kind, loving women. He worked to see himself as strong, rugged, and independent, and he disavowed his gentler, more tender side. He liked me as a therapist because he perceived me as rational and tough-minded, unlike the "mushy," "touchy feely" therapist he had seen previously and from whom he had fled.

Any thought or feeling can be used to defend against any other. Angry feelings can defend against feelings of abandonment or rejection, depression can defend against anger, haughtiness can defend against self-contempt, confusion can help us avoid facing painful truths, and relentless clinging to logic (like Spock in the original Star Trek) can help us ignore feelings of rage or humiliation.

We can be dismayingly unaware of an undesirable trait in ourselves and quick to attribute it to someone else instead (projection). We can mask an attitude by emphasizing its opposite, like the anti-pornography crusader who reveals his own fascination with pornography by constantly seeking out pornographic material to condemn (reaction formation). We can blandly disregard information that is right in front of our noses, like the mother who fails to see that her anorexic daughter is starving, or the therapist who doesn't hear a patient's references to a suicide plan (denial). We can think about emotionally charged topics in coldly abstract ways, like a patient of mine who tried to decide whether he was in love by doing a cost-benefit analysis (intellectualization). We can convince ourselves we are unafraid by plunging recklessly into the situation that frightens us (counterphobic

behavior). We can direct our feelings toward the wrong person, like the woman who is oblivious to her husband's infidelity but becomes enraged when she learns his friend is having an affair (displacement). We can induce feelings in another person that we cannot tolerate in ourselves, then try to manage them in the other person (projective identification). We can disclaim responsibility for our behavior by attributing it to circumstances outside our control (externalization). We are infinitely creative in finding ways to avoid or disavow what is distressing.

Certain defenses receive considerable external reinforcement. From time to time, a depressed patient will tell me during an initial consultation that their difficulties are due to a "chemical imbalance." This often means the person does not want to consider the possibility that their perceptions, expectations, choices, conflicts, relationship patterns, or anything else that is within their power to understand and change might be causing, maintaining, or exacerbating their suffering. In insisting their difficulties are due entirely to "chemical imbalance," such patients are often letting us know they do not wish to examine themselves.

This is a particularly pernicious defense because it is bolstered by messages from pharmaceutical companies (which have a financial incentive to portray emotional suffering as biological illness) and often by trusted doctors (who receive information from those same pharmaceutical companies). Such patients may regard any acknowledgment of a psychological component to their suffering as an intolerable admission of weakness or personal failure. The harsh self-condemnation that lies just beneath the surface of this attitude may be precisely what is perpetuating their depression, but their reluctance to examine themselves may preclude the kind of therapy that would lead to change. In such cases, I have found it best not to challenge patients' convictions directly, but to try to stimulate their curiosity and self-reflection in other ways. (For the record, I am *not* suggesting we can ignore biological factors or should not avail ourselves of pharmacological treatment options. I am suggesting that an appreciation of biology should not make us deaf and blind to psychology.)

Undergraduate psychology textbooks generally catalog *defense mechanisms*, but these presentations rarely foster a deeper understanding of psychoanalytic therapy. One problem with the term *defense*

mechanism is that it sounds, well, mechanistic, and the life of the mind is anything but mechanistic. Also, the term *mechanism*, a noun, makes it sound like a defense is a *thing*. It is more helpful to think of *defending*, a verb, as something people *do*.

Another problem is that *defense mechanism* implies a discrete process or event, which is also not quite right. Rather than being discrete events, ways of defending are woven into the fabric of our lives and reflected in our characteristic ways of thinking, feeling, acting, coping, and relating. Our ways of defending become part of our enduring personality or character. For example, some people characteristically immerse themselves in detail and miss the forest for the trees. The focus on concrete details takes the focus off difficult emotions. Other people seem unable to focus on details at all. Their perceptions of self and others seem glib and superficial. This defensive style may deflect attention from troubling facts. Some people feel superior and act self-important to help banish painful feelings of emptiness or inadequacy. Some people are chronically inattentive to their own needs but lavish care on others instead (a common pattern in psychotherapists). Defense and personality are inseparable.

Psychoanalytic psychotherapy helps us recognize the ways we disavow aspects of our experience, with the goal of helping us to claim or reclaim what is ours. This has the effect of expanding freedom and choice. Things that previously seemed automatic or obligatory become volitional, and life options expand. Of course, freedom and choice bring their own dilemmas. With choice comes responsibility, which can sometimes be terrifying. The desire to deny responsibility can therefore be a significant impediment to change.

Perhaps Erica Jong (1978) had this dilemma in mind when she wrote:

> No one to blame! … That was why most people led lives they hated, with people they hated … How wonderful to have someone to blame! How wonderful to live with one's nemesis! You may be miserable, but you feel forever in the right. You may be fragmented, but you feel absolved of all the blame for it. Take your life in your own hands, and what happens? A terrible thing: no one to blame.

In the section on *transference*, I described research showing that the most effective therapists address transference in psychotherapy (Ablon

& Jones, 1998; Jones & Pulos, 1993). The same research found that the most effective therapists also help patients recognize defenses by calling attention to them as they arise in treatment. Both types of interventions are empirically linked to good treatment outcome.

If we think of defense in systemic terms, as an effort to preserve equilibrium and homeostasis, then psychotherapy poses a paradox. People come to therapy to change, but change is a threat to equilibrium and homeostasis. Thus, every patient is ambivalent about treatment, oscillating between the desire to change and the desire to preserve the status quo. This ambivalence can be palpable at the start of therapy. Among patients who schedule appointments at our university clinic, roughly half do not keep their first appointment. I believe this is typical for many clinics. When patients telephone the clinic, they are expressing one side of an inner conflict, the side that seeks change. When they fail to keep their appointments, they are expressing the other side of the conflict, the side that seeks to maintain homeostasis.

I recall starting my own psychoanalysis. I scheduled my first appointment two weeks in advance. I thought about the upcoming appointment day and night throughout the two weeks. On the day of the actual appointment, however, it completely slipped my mind. When the analyst and I eventually managed to meet, he asked if it was like me to forget appointments. I told him with embarrassment it was not. He shrugged and said, "So, it seems you have an unconscious too." Psychotherapy is an ongoing tug-of-war between a part of us that seeks change and a part of us that strives to preserve the known and familiar, however painful it may be. As therapists, we side with the forces seeking growth.

I believe Freud (1912/1964) had this paradox in mind when he wrote: "The resistance accompanies the treatment step by step. Every single association, every act of the person under treatment must reckon with the resistance and represents a compromise between the forces that are striving for recovery and the opposing ones (p. 102)."

The terms *defense* and *resistance* are related. They refer to efforts to disavow or disclaim thoughts, feelings, or responsibility. More technically, resistance refers to defensive processes that emerge within the therapy relationship itself, that impede the shared task of exploration and inquiry. It is not particularly helpful to think of resistance as

opposition between therapist and patient. Rather, resistance arises out of conflict or discord *within the patient*. This can be difficult to keep in mind when resistance takes forms therapists find unpleasant, as when patients arrive late, miss appointments, fall silent, fill sessions with small talk, or ignore the therapist's comments. However frustrating for therapists, such behavior reflects the patient's efforts to maintain equilibrium. The therapist's best approach is alliance with the parts of the patient that seek growth and change. Ideally, patient and therapist develop a shared sense of curiosity regarding defensive processes, viewing them non-judgmentally, with a desire simply to examine and understand.

The concepts of defense, conflict, and unconscious mental life are intertwined. The word *unconscious* is really a form of shorthand, referring to the thoughts, feelings, and behaviors we disavow, repudiate, or defend against. We often see an active push and pull between defensive processes and the thoughts and feelings they defend against. As hard as we work to push them away, so hard do they seem to push back, seeking some form of outlet or expression. Thus, there is conflict or dynamic tension between the parts of us that get repudiated and the parts of us that do the repudiating. Psychoanalytic theorists use the term *dynamic unconscious* to remind us that unconscious thoughts and feelings are not dormant or inert, but actively seek expression. They influence our thoughts, feelings, and actions in indirect ways.[3]

Psychological Causation

Psychological symptoms often seem senseless. They serve no apparent purpose and often feel alien to the person suffering from them. Many depressed patients have told me their feelings of despair and sadness come on "out of the blue." Feelings of anxiety or even panic can also come on unpredictably. In fact, the DSM diagnostic criteria for panic disorder specify that the panic attacks come on "unexpectedly," that is, with no apparent cause.

[3] Note the word *unconscious* has a specific meaning in psychoanalytic theory. Many mental processes occur outside awareness, but we generally reserve the term *unconscious* for thoughts, feelings, and behaviors we actively repudiate and that actively seek expression. Thus, the word *unconscious* really means *dynamic unconscious*. Psychoanalytic theorists generally use other terms (such as *non*-conscious) to refer to mental processes that take place outside of awareness but are not conflictual or actively defended against.

However random or meaningless symptoms may seem, it is our working assumption that symptoms have meaning, serve a psychological purpose, and occur in a psychological context in which they are understandable. Because the psychological circumstances that contextualize a symptom may not be consciously accessible, a symptom may *appear* senseless or random. As a person's scope of awareness expands and they become better able to recognize and articulate a broader range of experience, the meaning and function of the symptom may become clear. Generally, as this occurs, the person is able to find new solutions to old problems and the symptom fades.

The more we are strangers to ourselves, the more random, accidental, and fragmented our experience may seem. Psychoanalytic therapy helps us recognize the connections that exist between thoughts, feelings, actions, and events. For example, if a patient says to me, "I don't know why I did that," I may respond by saying, "Let's see if we can look beyond 'I don't know.' Let's examine what happened before that." What happened before could be an external event or internal events like thoughts, feelings, memories, sensations, and images.

A patient recovering from a heart attack kept "forgetting" to take his medication. I put the word forgetting in quotation marks because the patient, whom I will call Steve, was an intelligent person and his memory was otherwise fine. Steve's doctors responded with "patient education," explaining why the medication was needed. Steve wanted to take care of his health and tried to follow his doctors' treatment plan. Still, he kept forgetting.

I suggested to Steve there might be more to his forgetting than meets the eye and asked if he had any ideas about this. Steve eventually said something about taking the medication gave him a bad feeling, but he could not say what. He genuinely did not know. I asked him to tell me any thoughts or feelings that occurred to him, whether or not they seemed relevant or made sense to him. Steve said he did not know why it came to mind just then, but he found himself thinking about his younger brother. As a child, Steve had been popular, athletic, and a good student. In contrast, his brother had been sickly and weak. He was always taking pills for one thing or another. He did poorly in school and was no good at sports. He was a disappointment to his parents.

Note the *sequence* of Steve's thoughts. His first thought was about taking medication. His next associations were to his sickly younger brother. We call the thoughts "associations" because we assume they are in some way linked to, or associated with, the preceding thoughts. On the surface the two topics seem unrelated, but our working assumption is that they are connected. In this case, the sequence of thoughts suggests a hypothesis: in Steve's mind, taking pills means being like his younger brother—weak, sickly, and less loved. If the hypothesis is correct, no amount of "patient education" would have sufficed. In fact, Steve stopped forgetting his medication only after we were able to discuss his fear of being weak and a failure, and his related fear of losing the love of the people who mattered to him. More specifically, Steve recognized that taking medication would not turn him into his brother. That was an irrational fantasy. The fantasy operated outside awareness, but it influenced Steve's behavior and could have cost him his life.

Another patient, who was a bit overweight, had periodic eating binges. She'd sneak to the McDonald's drive-through and order cheeseburgers and milkshakes. Afterward, she'd hate herself for it. She had tried for years to control her eating binges with little success. After an eating binge, I asked her to notice any thoughts that occurred to her, whether or not they seemed related to the eating binge. Her thoughts ran to her husband. She said he was self-centered and controlling and ignored her needs. She said he treated her as a trophy to display, not a human being with needs and feelings of her own. Her additional associations were that her husband was happy when she was thin because she was a better trophy, that she felt emotionally deprived and unloved, and she felt financially dependent on her husband and trapped in her marriage.

"Could it be," I wondered aloud, "that your eating binge was a way of getting back at your husband?" My comment was aimed at making explicit or conscious a potential link between thoughts, feelings, and actions that had thus far been implicit or unconscious. My patient had great difficulty acknowledging anger toward her husband even though she complained about him constantly, and it was a struggle for her to give my comment serious consideration. Eventually she began to put into words her anger, her revenge fantasies, and the thought that her husband was "such a prick that he doesn't deserve a thin wife."

My patient's eating binge was embedded in a complex web of associations and meanings. As it turned out, her behavior served simultaneously to punish her husband, to compensate for her emotional deprivation (because she associated food with love), to reassure herself that she was not under his control, to help suppress fantasies about leaving him (because being overweight would make her less desirable to other men), and to punish herself for her vindictive thoughts (because she hated being overweight).

This multiplicity of causes and meanings illustrates the concepts of *overdetermination* and *multiple function* that I mentioned earlier. In the life of the mind, we do not necessarily find simple, one-to-one cause and effect. A symptom or behavior may have multiple causes (overdetermination) and can serve multiple purposes (multiple function). All competent psychoanalytic therapists share a deep appreciation of the complexity of mental life. For this reason, psychoanalytic psychotherapy is not assembly-line therapy. It is not a collection of standardized techniques applied to all, nor can it be reduced to a step-by-step instruction manual. It relies on empathically attuned inquiry into the most private, personal, and deeply subjective aspects of inner experience. In this sense, no two treatments can ever be alike.

My patient did not experience a sudden insight or dramatic cure, and she had not come to treatment because of her secret visits to McDonald's. Nevertheless, over time, we were able to trace out some of the links in the complex web of meanings that gave rise to her eating binges. She slowly became more comfortable acknowledging and expressing anger, more aware of her own emotional needs, and better able to communicate them to her husband and others. Her relationship with her husband improved and her eating binges subsided. Eventually she reported that—for the first time in years—she was able to lose weight and keep it off, and it did not feel like a constant struggle. She never won the battle absolutely. Over the ensuing years, she did have the occasional binge—always when she was furious with her husband.

These examples are meant to illustrate how psychological symptoms are embedded in organized networks of thoughts, feelings, perceptions, and memories that contextualize them and give them meaning. This applies not only to symptoms but to *all* mental events. It is a working assumption of psychoanalysis that *nothing in the life of the*

mind is random. The mind is an elaborate associative network, with mental events linked to one another in meaningful, albeit complex, ways. Within certain broad parameters, all mental activity follows the logic of the associative network, whether or not the connecting links are explicit or conscious. This applies not only to thoughts, feelings, and memories, but also to dreams, daydreams, mistakes, and slips of the tongue (the infamous "Freudian slip"). It is possible to start with any seemingly random mental event and trace the multiple associations linked to it. Often, the event makes sense when the larger associative network becomes explicit.

An analogy to an associative network is the internet, where web pages are linked in intricately interconnected networks (Peebles-Kleiger, 2002). We can go to a web page, follow a link to another page, and then another and another. Within a few clicks we can get far indeed from our starting point. We could start on a page about global warming and end up, a few clicks away, on a page about Shakespearean sonnets. Somebody who looked at our computer screen at that moment might never guess how we got there. If we wanted, however, we could re-trace the sequence of links that brought us from where we started to where we ended, and we could explain why we followed those links.

Missing from the internet analogy is the role of affect. Unlike the web, where links are based mostly on content, mental associative networks are organized along affective lines. That is, things are connected that bring up similar feelings. *Associative pathways tend to lead to what is emotionally charged or problematic*. This has profound implications for therapeutic technique: if we allow ourselves to observe our thoughts without editing or censoring them and follow them where they lead, they often lead to what is troubling.

Contemporary research in cognitive science and neuroscience is based on the concept of mind as associative network and cognitive researchers have developed experimental methods to study associative linkages (for example, priming and reaction time experiments). Interestingly, the concept of associative pathways has *always* been central to psychoanalytic theory and practice. Freud was a master at tracing associative links to discover psychological meanings, untangling associative connections with a detective's precision. His thinking is most accessible and compelling in his 1904 (Freud, 1904/1964)

monograph, *The Psychopathology of Everyday Life*, which I recommend to all students and therapists. Certainly, there were instances where Freud was carried away by his own cleverness and guilty of reading questionable meanings into patients' associations. Those with an agenda to criticize will find ample ammunition in Freud's writings, but they would miss the point.

To help trace associative linkages, we ask our patients to say whatever comes to mind without editing or censoring their thoughts, encouraging them to observe their thoughts non-judgmentally (as in some forms of Buddhist meditation), without regard for whether or not the thoughts make sense or seem socially appropriate. This is called *free association*. Its purpose is to help make explicit associative linkages that are otherwise implicit. Every psychoanalytic therapist has a collection of phrases aimed at encouraging the free flow of thought and communication. We are constantly saying things like, "Can you say more about that?" and "What comes to mind?" and "What else occurs to you?" and "Where do your thoughts go from there?" and sometimes just "go on" and "uh huh."

In everyday social conversation, we automatically edit and censor our thoughts. We try to stay on topic, structure our thoughts to make coherent sentences, and edit out things that may embarrass or offend. Free association means suspending the usual editing and censoring and it often leads us places we could not have anticipated. Free association is therefore especially difficult for people who like to feel composed, collected, and in control. When patients describe therapy as "venting" or liken it to conversing with a friend (descriptions that have always struck me as deeply devaluing of psychotherapy), it is a sure sign they are *not* involved in a meaningful therapeutic process. No one who has engaged in genuine free association would ever liken therapy to ordinary conversation. Psychoanalytic therapy takes place at the edge, on the precipice of the abyss, at the border between the known and the unknown. There is nothing ordinary about it.

A male patient of mine, who was gay, made a slip of the tongue and called me by another person's name—let's say James. I asked him what occurred to him about the slip and he responded with the usual protestations that it was a random occurrence and meant nothing. I suggested we find out by seeing where his thoughts led. What did the

name James bring to mind? He recalled a friend of a friend who was named James, and he hastened to assure me this person meant nothing to him. "Okay," I said. "Perhaps he means nothing. All the same, where do your thoughts go next?" My patient paused, then blushed. James, he said, had been attracted to him and had wanted to seduce him. I asked, "Why does that embarrass you?"

It was not James's attempted seduction that embarrassed him. Rather, my patient had been working hard to push something out of his mind. That something was that *I* might be gay and want to seduce him. In fact, he had had a graphic daydream about it and had discussed it with his partner, who found the possibility intriguing. My patient resolved not to think about it again and not to mention it, yet here it was. His associations to his "random" slip of the tongue ran directly to what was most emotionally charged for him at that moment—as is so often the case.

To the reader who thinks this example sounds implausible, contrived, or biased by theoretical preconceptions, I say: try it. Next time you make a mistake, a slip of the tongue, or forget a word or a name, try free associating and follow your thoughts where they lead. It helps to write your thoughts down. At the point when you feel you are done and want to stop, ask yourself what comes to mind *next*. And after that, ask yourself what comes to mind *next*. Force yourself to push past the inner resistance you will encounter (e.g., "this exercise is stupid," "this is boring," "my thoughts aren't leading anywhere") and follow the chain of associations where it leads. Humor me if need be, but try it. You will never see the data if you are unwilling to conduct the experiment.

Officially, this non-randomness of mental processes is called *psychic determinism*. The term refers to the recognition that thoughts, feelings, behavior, and symptoms are not random or accidental, but are influenced or determined by the mental events preceding them. I prefer the term *psychic continuity* to psychic determinism. It reminds us there is continuity from one thought to the next, and thoughts and feelings are chained in meaningful associative sequences even when they seem unrelated or discontinuous. The term *determinism* has its roots in the mechanistic, materialist scientific zeitgeist of the 19th century and I am not sure its connotations are as helpful in our time.

I have encountered students who reject psychoanalytic approaches because they think, mistakenly, that psychoanalysis rejects free will and views behavior as determined by forces outside our control. The opposite may be closer to the truth. Psychoanalytic therapists believe expanding our understanding of the meanings and causes of our behavior *creates* freedom, choice, and a freer will. People can change, people *do* change, and psychoanalytic therapy helps people change, sometimes in profound ways. Every legitimate psychotherapist, deep down, believes in the human capacity to grow, change, and experience a greater sense of freedom and equanimity in the face of life's inevitable hardships. If behavior were unavoidably determined, there would be no reason to practice psychoanalytic therapy or, for that matter, any form of therapy.[4]

What's Good for the Goose

The reader may have noticed that I have written much of this chapter using the first-person plural pronoun "we." This is not an accident or literary convenience. It is meant to convey that the concepts and insights we apply to our patients apply equally to ourselves. The psychoanalytic sensibility draws no distinctions between the psychological principles that apply to patients and those that apply to psychotherapists. As Harry Stack Sullivan (As quoted in Sullivan, 1940) observed, "We are all more simply human than otherwise (p. 283)." Patient and therapist alike view self and others through the lenses of past experience, have unconscious mental lives, disavow what is threatening, form transferences, and reenact past relationship roles.

Some of my students have held the unfortunate preconception that psychoanalysis is a hierarchical, "one up" relationship between an emotionally removed, authoritarian doctor and a disempowered patient. I cannot in good conscience say this has never occurred; there was a time in the history of psychanalysis when some practitioners adopted a distant stance and spoke as authorities on patients' inner

[4] A patient of mine was once deeply struck when I pointed out a repetitive pattern in his life. In a moment of soul-rattling insight, he realized he had repeated the same mistake in his life time and again. He was highly intelligent but not terribly psychologically sophisticated. With the shock of recognition he blurted out, "It's true, it's true! I do exactly what you say, I see it!" And then, with consternation: "Why do I do this? Why do I keep doing it? Is this just the way I *am*?" I answered, "It's the way you've *been*." It was one of my favorite moments in therapy.

experience.[5] I can, in good conscience, say nothing could be more antithetical to the spirit of psychoanalysis. Psychoanalytic therapy is not something done *to* or practiced *on* another person. It is something done *with* another person. This does not mean psychotherapy is an equal or symmetrical relationship. There is no point denying the reality that one person has come to receive help and the other to offer it, that one person is paying the other a fee, and the circumstances inherently entail a power imbalance. But it does mean that therapy is a collaborative, shared effort between two people who must struggle to make sense together.

The psychoanalytic therapists I know and respect consider it a deep privilege to share so intimately in the inner, private life of another person, and there is something in the work that breeds in them a deep humility regarding what we can and cannot know and a deep humility regarding our capacity to help. I personally am not, by temperament, given to modesty or humility. I can nevertheless say sincerely that the longer I have practiced and the more I have learned, the more humble I have felt in my work with patients and the more deeply I have come to respect them. My patients and I share similar conflicts and struggles and we know similar pain. I have never treated a person so disturbed that I could not see something of them in me. Truly, we *are* all more simply human than otherwise.

Psychoanalytic therapy requires of the therapist a degree of intelligence, a degree of professional knowledge and skill, a capacity for empathic attunement with another person, a willingness to immerse ourselves in another person's private, subjective world, an absolutely ruthless willingness to examine ourselves, and for want of a better word, humanity. Of all the qualities that go into the making of a therapist, it is this last and most ineffable quality that may ultimately carry the day.

As for willingness to examine ourselves, it is difficult if not impossible to do meaningful psychoanalytic work without having meaningful psychotherapy experience ourselves. It may be the most important component of a clinician's training. Also, there is something that strikes me as hypocritical in asking our patients to do something we have

[5] I am inclined to think the best psychoanalysts never practiced this way, but certainly there were mediocre ones who did. In the past decades there have been sea changes in psychoanalytic theory and practice. Thankfully, this phase in the development of the profession is behind us.

been unwilling to do, something improper and unbecoming in asking our patients to follow their thoughts without censorship wherever they lead, when we have been unwilling to follow our own. There is nothing like the experience of being a patient to foster empathy for our patients and help us understand the powerful and often irrational feelings psychotherapy can stir up. We cannot truly understand transference or resistance by reading about it in a book or observing it in someone else. We must experience it firsthand. Nor is it sufficient to enter psychotherapy or psychoanalysis for "professional development" alone. We must enter it, like our patients, as suffering human beings.

Beyond this, the more we understand of our own conflicts and relationship templates, the better we can resist reenacting them with our patients. Personal psychotherapy or psychoanalysis does not guarantee we will succeed in this but at least it can give us a fighting chance. Too often, I have seen therapists recreate their personal pathology with patients. Therapists with histories of abuse who have not worked through their experience in personal therapy tend to be quick to declare their own patients to be victims, defining their experience for them instead of helping them to explore it for themselves. Therapists who have unresolved issues with the other gender may be quick to join patients in blaming, rather than helping them to better understand their own intimacy needs and the psychological obstacles to fulfilling them. Therapists who struggle with self-esteem difficulties may subtly demean their patients or offer shallow "affirmations" (like the kind caricatured by Stewart Smalley in old *Saturday Night Live* episodes), rather than offering them an opportunity to explore and rework their attitudes in ways congruent with their own personal history and lived experience. These are relatively blatant examples. More often, therapists enact their conflicts and relationship templates in more subtle ways.

Finally, meaningful personal psychotherapy engenders faith in the therapeutic process, and we require a great deal of faith when we find ourselves adrift in therapeutic seas. As Nancy McWilliams (2004) eloquently observed,

> The experience of an effective personal therapy or analysis leaves us with a deep respect for the power of the process and the efficacy of treatment. We know that psychotherapy works. Our silent appreciation of the discipline can convey that conviction to clients, for whom a sense of hope is a critical part of their recovery from emotional suffering. (p. 67)

Without hope, there can be no therapy.

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