That Was Then, This is Now:

Psychoanalytic Psychotherapy for the Rest of Us

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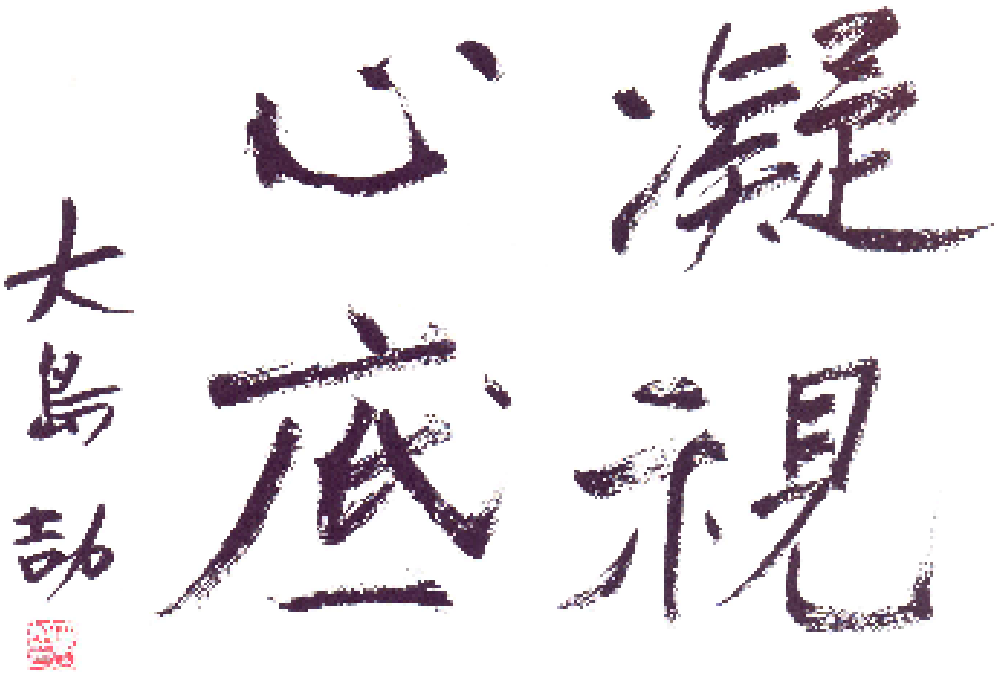

“Look at yourself honestly and unflinchingly to the very bottom of your mind.”

Calligraphy by Shihan Tsutomo Ohshima

Author's Note

This work-in-progress provides a jargon-free introduction to contemporary psychodynamic thought. It is intended for students, trainees, and clinical practitioners trained in other therapy approaches. I wrote it because the existing books did not seem to meet my student's needs. Many classic introductions to psychoanalytic thought are dated. They describe the psychoanalytic thinking of decades ago, not today. Other books assume prior knowledge that my students did not possess. Still others seem to have a partisan agenda of promoting one psychoanalytic school of thought over another, but the needs of trainees are ill served by drawing them into internecine theoretical disputes. Finally, some otherwise excellent books presume an interested and sympathetic reader, a presumption that is often unwarranted. Many trainees approach psychoanalytic concepts with pejorative preconceptions.

The title is a double *entendre*. "That was then, this is now" alludes to a central aim of psychoanalytic therapy, which is to free people from the bonds of past experience in order to live more fully in the present. People tend to react to what *was* rather than what *is*, and psychoanalytic therapy aims to help with this. The title also alludes to sea changes that have occurred in psychoanalytic thinking in the past decades. For many, the term "psychoanalysis" conjures up century old stereotypes that bear little relation to contemporary theory and practice.

The chapters that follow were intended as the beginning of a book. I may finish it someday, but the project is on the back burner. For now, this is it.

Jonathan Shedler
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Chapter 1:

Roots of Misunderstanding

Psychoanalytic psychotherapy may be the most misunderstood of all therapies. I teach a course in psychoanalytic therapy for clinical psychology doctoral students, many of whom would not be there if it were not required. I begin by asking the students to write down their beliefs about psychoanalytic therapy. Most express highly inaccurate preconceptions. The preconceptions come not from first-hand encounters with psychoanalytic practitioners, but from depictions in the popular media, from undergraduate psychology professors who refer to psychoanalytic concepts in their courses but understand little about psychoanalytic thought, and from textbooks that present caricatures of psychoanalytic theories that were out of date half a century ago.

Some of the more memorable misconceptions are: That psychoanalytic concepts apply only to the privileged and wealthy; that psychoanalytic concepts and treatments lack empirical support (for a comprehensive review of empirical evidence, see Shedler, 2010); that psychoanalysts reduce "everything" to sex and aggression; that they keep patients in long term treatment merely for financial gain; that psychoanalytic theories are sexist, racist, or classist (insert your preferred politically incorrect adjective); that Sigmund Freud, the originator of psychoanalysis, was a cocaine addict who developed his theories under the influence; that he was a child molester (a graduate of an Ivy League university had gotten this bizarre notion from one of her professors); and that the terms "psychoanalytic" and "Freudian" are synonyms—as if psychoanalytic knowledge has not evolved since the early 1900s.

Most psychoanalytic therapists have no idea how to respond to the question (all too common at cocktail parties), "Are you a 'Freudian?'" The question has no meaningful answer, and I myself fear that *any* answer I give will lead to

misunderstanding. In a very basic sense, *all* mental health professionals are "Freudian" because so many of Freud's concepts have simply been assimilated into the broader culture of psychotherapy. Many Freudian ideas now seem so commonplace, commonsense, and taken-for-granted that people do not recognize that they originated with Freud and were radical at the time. For example, most people take it for granted that trauma can cause emotional and physical symptoms, that our care in the early years profoundly affects our adult lives, that people have complex and often contradictory motives, that sexual abuse of children occurs and can have disastrous consequences, that emotional difficulties can be treated by *talking*, that we sometimes find fault with others for the very things we do not wish to see in ourselves, that it is exploitive and destructive for therapists to have sexual relations with clients, and so on. These and many more ideas that are commonplace in the culture of psychotherapy are actually "Freudian." In this sense, *every* contemporary psychotherapist is a (gasp) Freudian. Even the practice of meeting with clients for regularly scheduled appointments originated with Freud.

In another sense, the question "Are you a Freudian?" is unanswerable because no contemporary psychoanalytic therapist is a Freudian. What I mean is that psychoanalytic thinking has evolved radically since Freud's day—not that you would know this from reading most psychology textbooks. In the past decades, there have been sea changes in theory and practice. The field has grown in diverse directions, far from Freud's historical writings.

There are multiple schools of thought within psychoanalysis with competing and sometimes bitterly divisive views, and the notion that someone could tell you "the" psychoanalytic position on anything is quaint and naïve. There may be greater diversity of viewpoints within psychoanalysis than within any other school of psychotherapy, if only because psychoanalysis is the oldest of the therapy traditions. Asking a psychoanalyst for "the" psychoanalytic view may be as meaningful as asking a professor

of philosophy for "the" philosophical answer to a question. I imagine the poor professor could only shake her head in bemusement and wonder where to begin. So it is with psychoanalysis. Psychoanalysis is not one theory but a diverse collection of theories, each of which represents an attempt to shed light on one or another facet of human functioning.

What it isn't

It may be easier to explain what psychoanalysis is *not* than what it is. For starters, contemporary psychoanalysis is not a theory about id, ego, and superego (terms, incidentally, that Freud did not use; they were introduced by a translator). Nor is it a theory about "fixations," or sexual and aggressive instincts, or repressed memories, or the Oedipus complex, or penis envy, or castration anxiety. One could dispense with every one of these ideas and the essence of psychoanalytic thought would remain intact. (Surprised?) Some psychoanalysts find some of these concepts helpful, sometimes. Some psychoanalysts reject all of them.

If you learned in college that psychoanalysis is a theory about id, ego, and superego, your professors did you a disservice. I hope you will not shoot the messenger for telling you that you may be less prepared to understand psychoanalytic thought now than if you had never taken a psychology course at all. Interest in this particular model of the mind (known as the "structural theory") has long since given way to other approaches (cf. Person, Cooper, & Gabbard, 2005). In our lifetimes, the theory's strongest proponent eventually went on to argue that it is no longer relevant to psychoanalysis (Brenner, 1994). When psychology textbooks present the structural theory of id, ego, and superego as if it were *synonymous* with psychoanalysis, I don't know whether to laugh or to cry.

It is fair to ask how so many textbooks could be so out of date and get it all so wrong. Students have every reason to expect their textbooks to be accurate and authoritative. The answer, in brief, is that psychoanalysis developed outside of the academic world, mostly in freestanding institutes. For complex historical reasons, these institutes tended to be rather insular, and for decades psychoanalysts did little to make their ideas accessible to people outside their own closed circles. Some of the analytic institutes were also arrogant and exclusive in the worst sense of the word and did an admirable job of alienating others in the mental health community. This occurred at a time when American psychoanalytic institutes were dominated by a hierarchical medical establishment (for a historical perspective, see McWilliams, 2004). The psychoanalytic institutes have changed but the hostility they engendered in other mental health professions is likely to persist for years to come. It has now been transmitted across multiple generations of trainees, with each generation modeling the attitudes of its own teachers.

Academic psychology also played a role in perpetuating widespread misunderstanding of psychoanalytic psychotherapy. A culture developed within academic psychology that disparaged psychoanalytic ideas—or what it *mistook* for psychoanalytic ideas—and made little effort to learn what psychoanalytic therapists were really thinking and doing. Many academic psychologists were content to use psychoanalysis as a foil or straw man. They regularly "won" debates with dead theorists who were not present to explain their views (it is fairly easy to win arguments with dead people). Many academic psychologists continue to critique caricatures of psychoanalytic concepts and outdated theories that psychoanalysis has long since abandoned (cf. Bornstein, 1988, 1995; Hansell, 2005). Sadly, most academic psychologists have been clueless about developments in psychoanalysis for the better part of a century.

Much the same situation exists in psychiatry departments, which in recent decades have seen wholesale purges of psychoanalytically oriented faculty members, and which have become so pharmacologically oriented that many psychiatrists no longer know how to help patients in any way that does not involve a prescription pad. Interestingly, being an effective psychopharmacologist involves many of the same skills that psychoanalytic psychotherapy requires—for example, the ability to build rapport, create a working alliance, make sound inferences about things that patients may not be able to express directly, and understand the fantasies and resistances that almost invariably get stirred up around taking psychotropic medication. There seems to be a hunger among psychiatry trainees for more comprehensive ways of understanding patients and for alternatives to biologically reductionistic treatment models.

It may be disillusioning to discover that your teachers misled you, especially if you admired those teachers. You may even be experiencing some cognitive dissonance just now (and dissonance theory predicts that you might be tempted to disregard the information provided here, to help resolve the dissonance). I remember my own struggle to come to terms with the realization that professors I admired had led me astray. I *wanted* to look up to these professors, to share their views, to be one of them. It also made me feel bigger and more important to think like them and believe what they believed, and I felt personally diminished when they seemed diminished in my eyes. I suspect I am not alone in this reaction. I have often wondered whether this is one reason why otherwise thoughtful and open-minded students sometimes turn a deaf ear to psychoanalytic ideas.

Some comments on terminology

Throughout this book I will use the terms “psychoanalytic” and “psychodynamic” interchangeably. The term *psychodynamic* was introduced after World War II at a

conference on medical education and used as a synonym for *psychoanalytic*. I am told that the intent of those who coined the term was to secure a place for psychoanalytic education in the psychiatry residency curriculum, without unduly alarming psychiatry training directors who may have regarded "psychoanalysis" with some apprehension (R. Wallerstein, personal communication; Whitehorn et al., 1953). In short, the term *psychodynamic* was something of a ruse. The term has evolved over time to refer to a range of treatments based on psychoanalytic concepts and methods, but which do not necessarily take place five days per week or involve lying on a couch.

At the risk of offending some psychoanalysts, a few words are also in order about psychoanalysis versus psychoanalytic psychotherapy. In psychoanalysis, sessions take place three to five days per week and the patient lies on a couch. In psychoanalytic psychotherapy, sessions take place one to three days per week and the patient sits in a chair. Beyond this, the differences are murky. Psychoanalysis is an interpersonal process, not an anatomical position. It refers to a special kind of interaction between patient and therapist. It facilitates this interaction if the patient comes often and lies down, but this is neither necessary nor sufficient. Frequent meetings facilitate, in part because patients who come often tend to develop more intense feelings toward the therapist, and these feelings can be utilized constructively in the service of insight and change. Lying down can also facilitate, because lying down (rather than staring at another person) encourages a state of reverie in which thoughts can wander more freely. I will take up these topics in the next chapter.

However, lying down and meeting frequently are only trappings of psychoanalysis, not its essence (cf. Gill, 1983). With respect to the couch, psychoanalysts have come to recognize that lying down can impede as well as facilitate psychoanalytic work (e.g., Goldberger, 1995). With respect to frequency of meetings, it is silly to maintain that someone who attends four appointments per week is "in psychoanalysis"

but someone who attends three cannot be. Generally, the more often a patient comes, the richer the experience. But there are patients who attend five sessions per week and lie on a couch, and nothing goes on that remotely resembles a psychoanalytic process. There are others who attend sessions once or twice per week and sit in a chair, and there is no question that a psychoanalytic process is taking place. It really has to do with who the therapist is, who the patient is, and what happens between them.

Finally, I will generally use the term *patient* rather than *client*. In truth, both words are problematic, but *patient* seems to me the lesser of evils. The original meaning of *patient* is "one who suffers." But for some, the word has come to imply a hierarchical power relationship, or conjures up images of authoritarian doctors performing procedures on disempowered recipients. These connotations are troublesome because psychoanalytic psychotherapy is a shared, collaborative endeavor between two human beings, neither of whom has privileged access to truth. On the other hand, the term *client* does not seem to do justice to the dire, sometimes life-and-death seriousness of psychotherapy or the enormity of the responsibility therapists assume. My hairdresser, accountant, and yoga teacher all have "clients," but none to my knowledge has ever hospitalized a suicidal person, received a desperate nighttime phone call from a terrified family member of a person decompensating into psychosis, or struggled to help someone make meaning of the experience of being raped by her father.

Neither word is ideal, and some colleagues I respect prefer one word and some the other. I have tried to explain the reasons for my own preference. Readers with an aversion to *patient* may substitute the word *client* where they wish. The choice of terminology is less important than reflecting on the meanings and implications of our choice.[1]

[1] Nancy McWilliams (personal communication) has commented on the irony that many people have come to associate the mercantile rather than the medical metaphor with greater compassion and humanity.

Chapter 2:

Foundations

If psychoanalysis is not a theory about the id, ego and superego, or about fixations, or about repressed memories, what *is* it about? The following ideas play a central role in the thinking of most psychoanalytic practitioners. These ideas are intertwined and overlapping; I present them separately only as a matter of didactic convenience.

Unconscious mental life

We do not fully know our own hearts and minds, and many important things take place outside of awareness. This assertion should no longer be 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; Nisbett & Wilson, 1977; Westen, 1998; Wilson, Lindsey, & Schooler, 2000). Usually cognitive scientists do not use the word "unconscious" but refer instead to "implicit" mental processes, to "procedural" memory, and so on. The terminology is not important. What matters is the concept—that important memory, perceptual, judgmental, affective, and motivational processes are not consciously accessible. Psychoanalytic discussions of unconscious mental life do, however, emphasize something that 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 tend to 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, these were easy

interviews to conduct. Most people, with a little encouragement, enjoy talking about themselves to someone who is 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 all my questions cheerfully and cooperatively, I did not feel engaged at all. Slowly, I began to realize that Jill's answers to my questions amounted to a string of abstractions, clichés, and platitudes. I simply 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 'neurotic' means. That's the best word to describe her. I'm sure you've seen a lot of people like her."

After much questioning, Jill eventually told me that 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 a hostile, ungrateful daughter. I had to ask Jill repeatedly for a specific example of the kind of thing her sister complained about. 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." Eventually her kind, caring father lost his temper and held his seven

year old daughter underwater so long that she nearly drowned. As Jill told this story, the emphasis was entirely on how provocative her sister had been. Jill seemed completely unaware that she had just described an instance of 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 that Jill was trying to mislead me or hide the truth. What was striking was that Jill seemed entirely unaware that there were any conclusions to be drawn from these events other than that her sister was neurotic. This is a fairly dramatic example of the kind of thing I mean when I say there are things we seem not to want to know.

Please note that this vignette has nothing to do with "repressed memories." Repressed memories get a lot of attention in undergraduate textbooks and in media portrayals of psychoanalysis—and have virtually nothing to do with contemporary psychoanalytic psychotherapy. 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 to become more mindful of their experience in the here and now. To my knowledge, *none* of the therapists involved in widely publicized 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 alternate interpretations of her experience. 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 an environment that was terrifyingly unsafe. This touches on an important concept in psychoanalytic psychotherapy: Most psychological difficulties were once adaptive solutions to life problems. Difficulties arise when life circumstances change and

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. George Bernard Shaw once wrote, "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 just 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 my 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 romantic attractions to people who are unavailable. These attractions may represent an unconscious compromise between a desire for closeness and a 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 two people ensured that he did not develop a deeper relationship with either.

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 nurturance. 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 caring 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 partner pursues the other withdraws, and vice-versa. Deborah Luepnitz (2002) has written a moving book on psychoanalytic therapy that emphasizes 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 sharp 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 prize

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

check. He realized afterward that the accident of losing the check was not so accidental, but reflected his deep self-criticism and feeling of unworthiness.

There are many reasons why people disavow angry feelings. We may fear retribution or retaliation, we may fear that our anger will damage someone we love, we may fear that 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 evoked 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 that 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 the suffering they had endured, or his appreciation 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 chapter, 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, bingeing may express a desperate wish to devour everything, perhaps to fill an inner void. The symptom seems to say, "I am so needy and desperate 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 than this, 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 behavior. 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 these 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 belief systems 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 for empirical research describing competing cognitive decision processes which he called "System 1" and "System 2" (Kahneman, 2003). System 1 works intuitively and automatically and is relatively unresponsive to new information or changing circumstances. Its operations "are typically fast, automatic, effortless, associative, *implicit (not available to introspection)*, and often emotionally charged" (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. 697). These cognitive systems work in tandem and often produce contradictory 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 rigorously 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; Westen & Gabbard, 2002a, 2002b).

The past is alive in the present

Through our earliest experiences we learn certain templates or scripts about how the world works (a cognitive scientist 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. Another way of saying this is that *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 dotes on her and comforts 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 that her therapist is interested primarily in her aches and pains and seems confused by her invitation to talk about her emotions.

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 where 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 her idealization and her 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 turning the therapist into a victim), and finds another naïve therapist to rescue her from the damage inflicted by the first. This scenario may sound extreme, but the seasoned therapist will recognize a familiar pattern (e.g., Davies & Frawley, 1992; Gabbard 1992). It is a pattern characteristic of certain patients we describe as having borderline personality disorder.

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. He is profoundly sad for a time, goes through a period of mourning, but eventually recovers and goes on to love again. A person who experienced his childhood as a string of failures, rejections, and losses also experiences the death of a spouse. For him, the loss becomes a recapitulation of earlier losses and proof that his efforts in life can lead only to disappointment. He sinks into a bitter, angry depression and does 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, systems oriented therapists may note the repetition of family dynamics across generations, behaviorists may speak of conditioning 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 his previously formed templates, scripts, or schemas to organize his 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 him a seat, and invite him to tell me why he has come. But I am *not* the same person in the eyes of the 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 of us can diverge from our perceptions of ourselves 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 hone in on our very real limitations, vulnerabilities, and insecurities with laser-like precision. But that is a topic for a later chapter.)

When I was in graduate school, a friend of mine entered therapy with a man whose last name sounded something like "Hiller." In the eyes of virtually everyone, Dr. Hiller was a gentle and compassionate man who was rather meek and self-effacing. 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 go through this phase, and essential that her therapist was able to tolerate this perception of him. Rather than trying to convince her otherwise, he allowed her to have her own perception and patiently explored the thoughts, feelings, and memories that lay 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 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 that he viewed people with distrust and suspicion. It was another thing 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 that they were 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 with me was central to his recovery. Repeatedly I would point out, as gently as I could, 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 what you've experienced, it's not surprising that you now expect the same treatment from me." Or, "You're letting me know that our work means nothing to you, that you couldn't care less if we never saw each other again. I wonder whether you are convinced that I will disappoint and hurt you, and are rejecting me first in order to protect yourself."

Over time he came to understand—not in an intellectual way, but in an immediate, emotionally impactful way—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 that our patients' 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 to become palpable and salient. 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 this is 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 manualized interventions specified by the study protocol.

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 and powerful 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 provide 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 any and all of the untamed feelings we once experienced toward our earliest 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 why psychoanalytic therapy can accomplish more when meetings occur several times per week. By the same token, some relatively disturbed patients cannot tolerate the intensity and do better in once or twice per week treatment.) 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 very little about the therapist's. 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 that 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 (Safran, 1998; Safran & Segal, 1990), and I was a bit surprised when I heard my students who identify themselves as "radical behaviorists" discussing something 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 that I find it disconcerting when adherents of other therapy traditions invent new names for phenomena that psychoanalytic practitioners have recognized for generations, and then proceed to discuss them as if they were new discoveries.

I would be remiss in concluding this section on transference without acknowledging some of the newer, postmodern movements in psychoanalytic thought, which add a corrective to earlier, mechanistic, and now discredited views of transference as something created solely by the patient. In the hands of a dogmatic, authoritarian, and unreflective therapist (attitudes that have no place in any form of psychotherapy), the concept of transference can be misused. It can become a way of blaming the patient for our own limitations and failings. For example, if a therapist treats a patient rudely and callously, it would be a travesty of psychoanalytic technique to interpret the patient's resulting hurt and anger as a pathological "transference" distortion. Postmodern psychoanalysts who advocate relational and intersubjective approaches (remember the diversity of psychoanalytic theories I mentioned earlier?) remind us that our patient's reactions do not occur in a vacuum, and that patient and therapist mutually influence one another in complexly reciprocal ways. They are, in fact, co-constructing or co-creating each interaction.

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 therapeutic interaction, that early relationship templates become reactivated and replayed, and that unresolved hurts and longings get directed toward the therapist. It also seems undeniable that the way the therapist interacts and responds 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 that 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 his or her 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 (2004) describes defense in the context of systems theory. Systems (biological and psychological) regulate themselves to preserve equilibrium or homeostasis (for example, biological regulatory processes work to keep our body temperature near 98.6 degrees Fahrenheit despite considerable 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 that the system will reorganize in a more adaptive way. Analogously, psychoanalytic therapists work to disrupt homeostatic processes that maintain problems in living.

Older psychoanalytic writings refer to *repression* of thoughts and feelings, but I no longer find the term particularly helpful and it is my impression that other contemporary psychoanalytic writers also struggle for better words. I believe the word contributes to mystification of something that is very simple, ordinary, and commonplace. Bruno Bettelheim (1982) has argued that the word "repress" may be a poor translation of the German word that 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 abusive. She defended against this recognition by keeping her thoughts about her family members at the level of generalities and by not focusing on details. People often think and speak in generalities when attention to the specifics would call into question cherished beliefs. Jill did not make a conscious decision to think and speak in generalities. This was something she did habitually and reflexively, without realizing she did it. 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 the gravity with which I regarded her account of how her father had nearly drowned her sister, Jill quickly sought to reassure herself and me that the event had 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 the character 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 others instead (projection). We can mask an attitude by emphasizing its opposite, like the anti-pornography crusader who reveals his own fascination with pornography by seeking out pornographic material to protest and condemn (reaction formation). We can blandly disregard information in front of our noses, like the parent who fails to notice that her anorexic daughter is starving, or the therapist who fails to hear her 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 or not he was in love by doing a cost-benefit analysis (intellectualization). We can convince ourselves that 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 that his friend is having an affair (displacement). We can induce feelings in another person that we cannot tolerate in ourselves and then try to manage them in the other person (projective identification). We can disclaim responsibility for our behavior by attributing it to circumstances beyond our control (externalization). We are infinitely creative in finding ways to avoid or disavow what is distressing.

In recent years I have come across a particularly dismaying form of defense that can make psychotherapy very difficult. A depressed patient will tell me during our initial consultation that his difficulties are due to a "chemical imbalance." This often means that the patient does not want to consider the possibility that his perceptions, expectations, choices, conflicts, relationship patterns, or anything else that is within his power to understand and change might be causing, maintaining, or exacerbating his suffering. In insisting that their difficulties are due entirely to a "chemical imbalance,"

such patients are often letting us know that they do not wish to examine themselves. This is a particularly pernicious defense because it is bolstered by messages from pharmaceutical companies (which have an obvious economic incentive to portray emotional suffering as a biological illness) and often by trusted doctors (who receive much of their 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-judgment and self-condemnation that lies just beneath the surface of this attitude may be precisely what is perpetuating the 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 absolutely *not* suggesting that we can ignore biological factors, or should not avail ourselves of pharmacological treatment options. I am suggesting that an appreciation of biology should not cause us to become deaf and blind to psychological phenomena.)

Undergraduate psychology textbooks generally catalog *defense mechanisms*, but these presentations rarely foster a deeper understanding of psychoanalytic therapy. One difficulty with the term *defense mechanism* is that it sounds, well, mechanistic, and the workings of the mind are 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 are reflected in our characteristic ways of thinking, feeling, acting, coping, and relating. 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 of 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 from awareness painful feelings of emptiness or inadequacy. Some people are chronically inattentive to their own needs but lavish care on others instead (a common pattern among mental health professionals). Defense and personality are inextricably intertwined.

Psychoanalytic psychotherapy helps us recognize the ways in which 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 be terrifying. The desire to deny responsibility can therefore be a significant resistance to change.

I believe Erica Jong 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 help patients

recognize defenses by calling attention to them as they arise in therapy. Both types of interventions are empirically linked to successful 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 necessarily represents 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 a week in advance. I thought about the upcoming appointment day and night throughout the week. 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 that 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 what is known and familiar, however painful that may be. As therapists, we side with the forces seeking growth.

I believe Freud (1912) 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."

The terms *defense* and *resistance* are closely 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 that therapists find unpleasant, as when patients arrive late, miss appointments, fall silent, talk about unimportant things, ignore the therapist's comments, and so on. However frustrating for therapists, such behavior reflects the patient's efforts to maintain equilibrium. The therapist's best approach is alliance with those 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. We will revisit this in later chapters.

The concepts of defense, conflict, and unconscious mental life are intertwined. The word *unconscious* is merely a form of shorthand, referring to the thoughts, feelings, and behaviors that 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 those parts of us that repudiate and those parts of us that get repudiated. 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 may feel alien to the person suffering from them. Many depressed patients have told me that 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.

However random or meaningless symptoms may seem, it is our working assumption that symptoms have meaning, serve psychological functions, and occur in a psychological context. 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 she becomes 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 patient 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

[3] Note that the word *unconscious* has a specific meaning in psychoanalytic theory. Many mental processes take place outside of awareness, but we generally reserve the term *unconscious* for thoughts, feelings, and behaviors that 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 that are not conflictual or actively defended against.

we can look beyond 'I don't know.' Let's examine what happened before that." What happened before could be an external event or thoughts and feelings about an event.

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 for other things was just fine. Steve's doctors responded with "patient education," explaining why the medication was necessary. Steve wanted to take care of his health and he tried to follow his doctors' treatment plan. Still, he kept forgetting.

I suggested to Steve that there might be more to his forgetting than meets the eye, and I asked if he had any ideas about this. Steve eventually said that 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 any sense. 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 little 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 is equated with being like his younger brother—weak, sickly, and less loved. If the hypothesis is correct, no amount of "patient education" would have sufficed, despite his doctor's best efforts. 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 the 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 but 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 disregarded her needs. She said he treated her as a trophy to display, not as a human being with 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 that she felt dependent on her husband and trapped.

"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 despite the fact that 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 vengeful 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 "cookie-cutter" therapy. It is not a collection of techniques we can apply rotely, nor can it be reduced to a step-by-step 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 binge eating. She slowly became more comfortable acknowledging and expressing anger, more aware of her emotional needs, and better able to communicate her needs to her husband and to 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 organization of the World Wide Web, where web pages are linked in an intricately interconnected network. We can call up a web page, follow a link to another page, and then another and another. With a few mouse clicks we can get far indeed from our starting point. We could start on a page about Shakespearean sonnets and end up, just a few mouse clicks away, on a page about global warming. Somebody who looked at our computer screen at that moment might never guess how we got there. If we wanted, however, we could 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, of course, is affect. Unlike the web, where links are based mostly on content, mental associative networks are organized along affective lines. *Associative pathways generally 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 we 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 many experimental methods to study associative linkages (e.g., priming experiments, 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 monograph, *The Psychopathology of Everyday Life*, which I recommend to all students of psychoanalytic therapy. 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 certain forms of Buddhist meditation), without regard for whether or not the thoughts make sense or seem socially appropriate. Technically, this is called *free association*. Its purpose is to help make explicit associative linkages that are normally 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 more 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 that 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 that 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 that 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 and 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 he had discussed it with his partner, who found the possibility intriguing. My patient had resolved not to think about it again and not to mention it, and 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 are leading nowhere”) 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 do not 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 that there is continuity from one thought to the next, and that 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 helpful in our time.

I have encountered students who have rejected psychoanalytic approaches because they believed, mistakenly, that psychoanalysis rejects free will and views all behavior as determined by forces outside our control. Actually, the opposite may be closer to the truth. Psychoanalytic therapists believe that 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 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 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 therapists. As the psychoanalyst Harry Stack Sullivan (1954) observed decades ago, "We are all more simply human than otherwise." 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 subordinate patient. I cannot in good conscience say that this has never occurred; there was a time when many psychoanalysts adopted a distant, withholding stance toward their patients.[5] I can in good conscience say that nothing could be further removed from, or 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 that therapy is an equal or

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[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 that he had repeated the same mistake in his life again 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.

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

symmetrical relationship; there is no point in denying the reality that one person has come to receive help and the other has come to offer it, and one person is paying the other a fee. But it does mean that therapy is a collaborative, shared effort between two people who must struggle to make sense together (Buirski & Haglund, 2001).

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 I see in them pain that I have known myself. I have never treated a person so disturbed that I could not see something of him or her in me. Truly, we *are* all more 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 a meaningful therapy experience ourselves. Also, there is something that strikes me as hypocritical in asking our patients to do something that we have been unwilling to do ourselves, 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 to help us understand the powerful and often irrational feelings that therapy 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 therapy for the sake of "professional development." 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 that 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 their patients. Therapists with histories of sexual abuse, who have not worked through their experience in personal therapy, tend to be quick to declare their own patients victims, defining their patients' experience for them rather than allowing them to explore it for themselves. It is my impression that the therapists (if they deserve to be called that) who have created furors over false memories fall into this category. Therapists who have unresolved issues with the opposite sex may be quick to join patients in "male bashing" or "female bashing" rather than helping them to understand their intimacy needs and the psychological obstacles to fulfilling them. Therapists who struggle with self esteem difficulties may subtly demean their patients, or offer them shallow "affirmations" of the kind caricatured by Stewart Smalley on *Saturday Night Live*, rather than offering an opportunity to explore and rework their attitudes in ways congruent with their personal history and experience. These are relatively blatant examples. More often, therapists enact their conflicts and relationship templates in more subtle ways.

Finally, meaningful personal therapy engenders faith in the therapeutic process, and we require a great deal of faith when we are 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.” Without hope, there can be no therapy.

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