

# **Introduction to Theories of Mind and Psychotherapy**

**January 25, 2012 - February 29, 2012**

**PGY-1 Curriculum  
Residency Program  
Department of Psychiatry, UCSF School of Medicine  
Langley Porter Psychiatric Hospital and Clinics**

**Adam Goldyne, M.D.**  
3701 Sacramento Street, #131  
San Francisco, CA 94118  
(415) 826-9639  
[agoldynemd@mac.com](mailto:agoldynemd@mac.com)

## Class Sessions

- 1/25/12**            **The role of theories of mind and psychotherapies in clinical psychiatry**  
**Approaches to learning theories of mind and psychotherapy**
- 2/1/12**             **An overview of different types of psychotherapy**
- 2/15/12**           **A “family tree” of cognitive and behavioral schools and therapies**
- 2/22/12**           **An introduction to psychoanalytic (psychodynamic) psychotherapy**
- 2/29/12**           **A “family tree” of psychoanalytic (psychodynamic) schools of thought**

**January 25, 2012**

**The role of theories of mind and psychotherapies in clinical psychiatry**

**Approaches to learning theories of mind and psychotherapy**

# PSYCHOTHERAPY AND THEORIES OF MIND: THEIR ROLE IN PSYCHIATRY AND HOW TO LEARN ABOUT THEM

Adam Goldyne, M.D.

## I. What is the mind?

---

“Mind” is a term used to describe human **experiences** such as thinking, feeling emotion, and being motivated in one way or another. It also encompasses **capacities** such as thought, memory, learning, conscience, regulation of emotions, and many others. Such experiences and capacities are generated by the brain as it interacts with environmental input through the sensory system and acts on the environment through multiple body systems, including the musculoskeletal, endocrine, cardiovascular, gastrointestinal, and peripheral nervous systems.

## II. If mind is generated by brain, why not simply study the brain?

---

We understand that experiences such as thinking, feeling, and wanting and capacities such as reasoning, reality testing, and emotion regulation emerge from the functioning of the brain. However, that understanding rarely helps to guide us in conceptualizing our patient’s problems or in speaking or interacting with them in a manner which might alleviate their troubles. For this purpose, we need to think and speak in the language of experience. This language — “thoughts,” “feelings,” “desires,” “experiences” — is psychological and must be used even if psychological life is brain-based. As a useful analogy, consider that, even though a computer is ultimately run by chips processing 1s and 0s, thinking about this is not really related to using a program or to help someone browse the web. That is more usefully done at the level of software and the language involved is totally different.

## III. What is the value of theories of mind to a psychiatric clinician?

---

Theories of the mind give us the tools for thinking about the way a person’s subjectivity is *unique* and differs from that of other individuals. Given the infinite combinations of individual experience and genetics, it makes sense that our patients’ mental problems will have to be considered on a case-by-case basis. Categories like those in the DSM-IV-TR, which describe patterns of conscious thought, behavior, and emotion, are insufficient to fully describe the problems psychiatrists are asked to help with. To say that a person has Major Depressive Disorder describes only how that individual is *like* others with MDD and does not describe at all what makes that person’s psychology *unique* and *unlike* that of any other person with MDD. This is where describing that individual’s specific patterns of emotion, thinking, feeling, desires, views of herself and others, capacities, etc becomes relevant. It is this *specific* level of understanding that guides us in offering a personally meaningful kind of assistance to patients. Theories of the mind guide us in understanding people in this way.

#### IV. What is psychotherapy?

---

**Psychotherapy** is a form of treatment in which a professional *interacts* with a patient in a manner intended to improve that patient's mind. I could have defined psychotherapy more narrowly, as a treatment in which *talking* is intended to improve the patient's mind, but this would leave out the contemporary appreciation of the extent to which aspects of interaction other than talking (e.g., "body language," tone of voice, rate of speech, office policies, boundaries, etc) are critical to the effect of the treatment. There are also forms of psychotherapy, e.g., behavior therapy, in which writing things down, role playing, and other non-talking activities are prominent.

Outpatient psychotherapy usually involves sessions in which both doctor and patient acknowledge interaction as the primary mode of treatment. However, I am hard pressed to think of a clinical situation in which the way the clinician interacts with your patient will not bear heavily on the treatment outcome, even when another intervention — medications, ECT, seclusion, restraint, or a medical procedure — is being identified as the central therapeutic focus. For this reason, I propose that you conceive of psychotherapy as being a component of *all* clinical encounters in which the patient is conscious. I have constantly been impressed by this in my practice of psychopharmacology, inpatient psychiatry, emergency psychiatry, and consultation-liaison psychiatry.

#### V. Why should we study *multiple* perspectives on the mind? Isn't there consensus about how it works?

---

Psychology is not yet mature enough as a science to have a consensually-accepted paradigm for understanding mental life. Likewise, psychotherapy is not a mature enough discipline to have converged into a unified approach with consensus about optimal treatment. Rather, when it comes to matters of the mind and psychotherapy, there are multiple overlapping **perspectives, schools, or theories of mind**. None of them is complete or obviously superior in all ways. Each perspective has strengths and weaknesses, and each offers unique concepts that inform our attempts to understand our patients.

#### VI. What is the optimal way to learn about theories of mind?

---

No matter how depthful it is, a course like this can do little more than skim the surface of the extensive bodies of literature that comprise the theories of mind we will survey. In part, you will pick up theories of mind from supervisors, colleagues, and didactics, but if you wish to develop a mature professional perspective on even one of the theories of mind we will study it will require lifelong study involving in-depth reading. This is because there are many significant thinkers and sophisticated concepts in each field, and because ideas are in constant evolution.

## VII. What is the optimal way to learn to do psychotherapy?

---

Doing psychotherapy is a *skill*. Although the study of theory, concepts, and technique contributes to learning the skill, it is not enough. In some ways, learning to do psychotherapy can be compared to learning to play an instrument. To learn to play music optimally, one:

- (1) learns to read music and studies music theory
- (2) practices daily
- (3) has lessons
- (4) brings creativity, passion, and dedication.

These four components synergize with each other to build skill. Learning psychotherapy is similar:

- (1) Didactics are important, but are incomplete without deep solitary reading to expand knowledge and technique.
- (2) Regular practice of psychotherapy is critical and learning about theory and technique in a vacuum will be of little use.
- (3) The practice of psychotherapy does not mature adequately without supervision and feedback via which one presents one's techniques to a more mature therapist and receives feedback. The feedback further develops one's ideas and technique. This is *especially* true because the highly personal events of psychotherapy are not something one should discuss in a setting other than supervision.
- (4) Good psychotherapy is not something one approaches casually. It is hard work and requires passion and creativity. Like playing an instrument (and like medical procedures such as surgery), there is a definite craft to psychotherapy, but great psychotherapists are distinguished by their artistry.

In one important way, learning psychotherapy is different from learning other skills: the ability to *do* therapy is greatly enhanced by having oneself undergone a comprehensive and good open-ended (and often long term) therapy. The reasons are as follows (adapted from McWilliams 2004):

- By alerting us to the troubled parts of ourselves, therapy helps us appreciate in a deep way that our patients — no matter how disturbed — are more similar to than different from us. This helps us avoid a real job hazard: seeing patients as “screwed up” and feeling contempt for them in order to protect a personal sense that we are not troubled.
- Intimate contact with one's own therapist provides an exposure to the minute workings of therapy that no amount of reading, supervision, and practice can simulate.

- Without having been in psychotherapy, there is no way to understand, emotionally as well as intellectually, how profoundly a person can be influenced by unconscious factors and how many blind spots each of us has. Multiple “a ha” moments in which one comes to recognize what one has never previously been put into words builds a conviction about a part of human nature (unconscious experience) that is very difficult to accept based on book learning alone. This, in turn, helps one maintain conviction that therapy can help our patients even when they are having contagious moments of doubt.
- Being familiar with one’s own “dark side” allows one to empathize with one’s patients various wishes and impulses.
- An intense enough personal therapy allows one to get in touch with the extent to which patients idealize the therapist, with the yearning for dependency, the gratitude towards a caring listener, and the tremendous impact a therapist can have. (Paraphrased from Yalom, as quoted in McWilliams, 2004) Another way to say this is that, without having been in the patient role, we cannot fully empathize with what it is like to be in the patient role.
- Patients evoke strong countertransference feelings and defensiveness in us. Acting on that defensiveness can only be to the patient’s detriment. By contrast, recognizing one’s own countertransference allows one to use it in the service of understanding and helping the patient.
- One’s own therapy maximizes the chance that one will have a satisfying life outside one’s profession, thereby minimizing the risk of harming patients by unconsciously using them to meet our unmet personal needs.

### **VIII. How to maximize psychotherapy learning during residency**

---

Because of all the various demands of psychiatric training at UCSF, most residents seem to get two to three years of actual psychotherapy experience during residency. Furthermore, didactics only skim the surface of theories of mind and psychotherapy. Thus, I would recommend the following for maximizing psychotherapy learning during residency:

- Begin your own psychotherapy as early as possible in residency. Unless you have a specific, acute disorder which might demand another kind of therapy, I would recommend an open-ended psychotherapy via which you can get to know yourself, work through troubles, and develop as a psychotherapist in all the ways noted above. If you need to go once a week, that is understandable (especially early in residency), but if you can go twice a week or more that would be optimal for reasons we will cover later in this course. I am more than happy to serve as a confidential resource for referring you to psychotherapists. In doing so, there will be no need to share your personal issues with me. Simply let me know you are interested and I

will do my best to make sure you find a talented therapist with whom you are comfortable.

- Read, read, read above and beyond readings assigned for classes. I will provide a reading list with which to begin.
- Try to begin doing psychotherapy as early as you can in residency. I believe that most residents do not get a long term case until some time in third year. If you can, get one early in the year. If you can, get more than one. If at all possible (and I don't know if it is), request a case beginning in your second year.
- Try to get good supervision in as many modalities of psychotherapy as you can.
- Discuss cases with your colleagues and maximize opportunities for peer supervision.
- Accept the fact that psychotherapy training only begins in residency. It is a lifelong learning process and, for those of you who are serious about it, supervision and / or advanced training should be pursued after residency.

*Further reading on becoming a psychotherapist:*

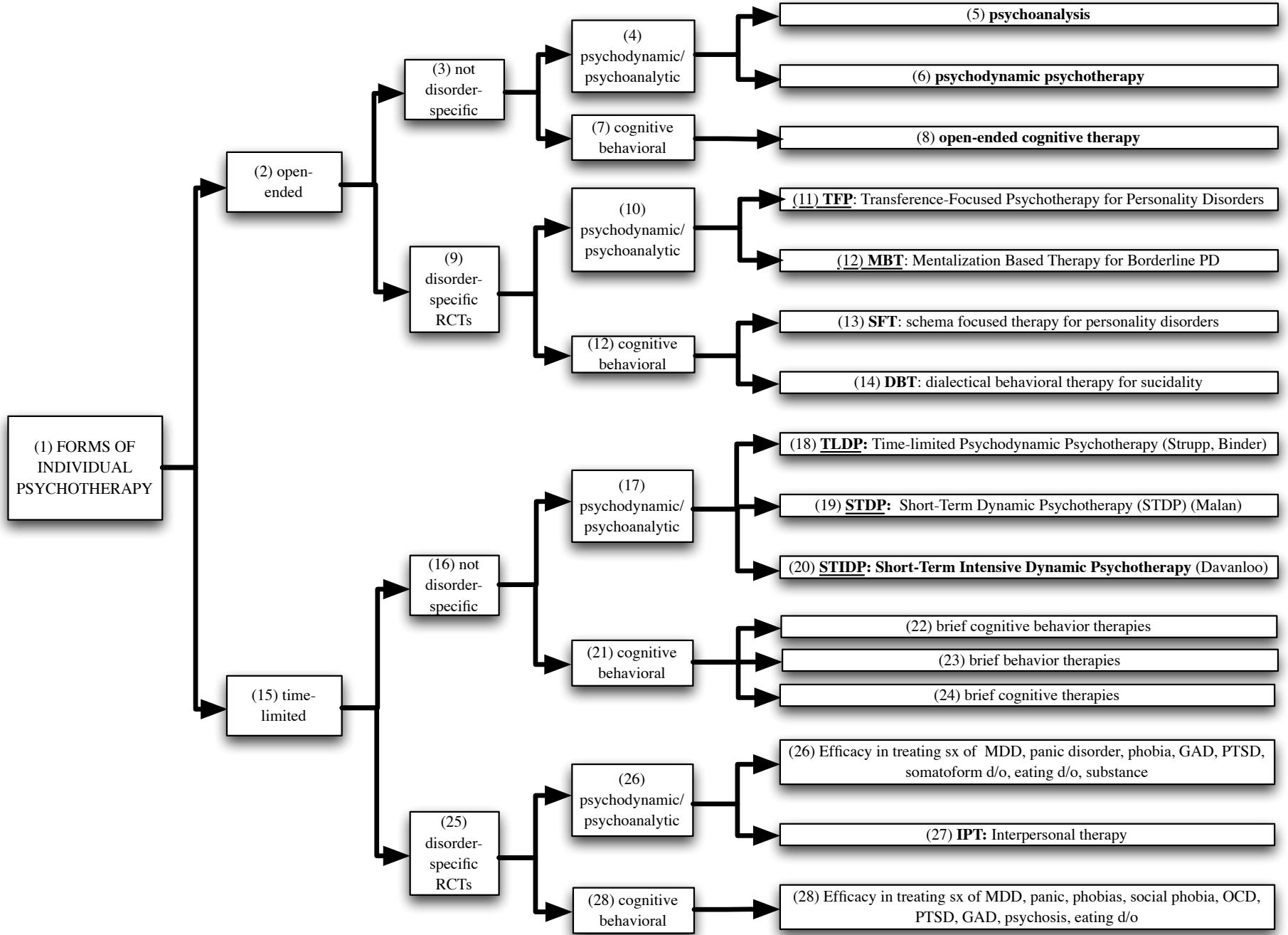
“The Therapist's Preparation,” Chapter 3 in McWilliams, N. (2004). Psychoanalytic psychotherapy : a practitioner's guide. New York, Guilford Press.

**February 1, 2012**

**An overview of the different types of psychotherapy**

Introduction to the diagrams

Each of the attached diagrams is labeled with number — e.g., (1) — that keys them to accompanying text descriptions. Please study both diagrams and accompanying text before class.



<p>(1) <b>Forms of individual psychotherapy.</b> This diagram does not cover group and couple treatments.</p>	<p>(7) <b>Cognitive behavioral.</b> These psychotherapies use <i>cognitive techniques</i> (which actively elicit, and attempt to modify, thoughts and emotions) and <i>behavioral techniques</i> (environmental manipulations and encouragement of new behaviors) to affect changes in thoughts, feelings, and behaviors. Newer therapies also focus on Zen concepts such as mindfulness and acceptance. Compared with psychoanalysis and psychoanalytic psychotherapy, there is likely to be less attention to the therapeutic relationship or on patterns that the patient has not yet recognized.</p>	<p>(12) <b>Mentalization-Based Therapy (MBT).</b> A treatment for Borderline Personality Disorder developed by Peter Fonagy in England. In community practice, this therapy is likely to be open-ended. In RCT (Fonagy et al, 2008), it involved 18-month, intensive, psychodynamic partial-hospital approach for Borderline patients, followed by 18 months of group. Five years after conclusion treatment, subjects were doing spectacularly better than standard psychiatric treatment in terms of suicide, resolution of BPD, hospitalization, need for medication, global functioning, and vocational status.</p>
<p>(2) <b>Open-ended psychotherapies.</b> In clinical practice, these are psychotherapies that end when patient and psychotherapist agree it is appropriate.</p>	<p>(8) <b>Open-ended cognitive behavioral therapies.</b> Traditionally, cognitive and behavioral therapies have not been open ended. They have had highly structured, brief courses, focusing heavily on specific symptoms determined at the outset. However, over time cognitive therapists have turned towards treatment of more deeply-entrenched and complicated problems that do not yield to time limits, and thus have begun to work in more open-ended ways.</p>	<p>(13) <b>Schema Therapy.</b> A manualized treatment for personality disorders developed by Jeffrey Young in New York. Adds some psychodynamic understanding of personality (“object relations”) to a mostly cognitive framework. A Netherlands study found it superior to TFP for borderline patients, but therapists in the TFP arm of the trial were trained by an instructor who has written that they did not adequately learn or deliver TFP.</p>
<p>(3) <b>Not-disorder specific.</b> These psychotherapies are not targeted to a specific psychiatric disorder. Rather, the therapist discovers the patient’s thoughts, feelings, motivations, and behaviors in a totally individualized way and tailors treatment accordingly.</p>	<p>(9) <b>Disorder-specific, RCT tested:</b> In order to demonstrate efficacy, psychotherapists have begun to subject their techniques to RCTs, many of which have demonstrated significant benefits.</p>	<p>(14) <b>Dialectical Behavioral Therapy (DBT):</b> A manualized treatment for Borderline PD developed by Marsha Linehan in Seattle. Has become deeply entrenched as a standard of care for BPD due to it’s head start in conducting RCTs. Reduces suicidality, self-injury at one year, but not at long term follow-up. A recent RCT (McMain et al, 2009) showed no differences at one year between treatment by psychiatrists using APA guidelines and treatment with DBT.</p>
<p>(4) <b>Psychodynamic / psychoanalytic.</b> These psychotherapies are rooted in the theories and psychotherapy techniques of psychoanalysis, which was introduced by Sigmund Freud has been extended by thousands of thinkers over the last 100+ years.</p>	<p>(10) <b>Psychodynamic disorder-specific RCTs.</b> Psychodynamic clinicians consider personality problems a specialty. They lagged behind DBT by a few years in conducting RCTs for personality disorders, but once they did they were able to demonstrate efficacy that is at least equal to, and potentially superior to, DBT.</p>	<p>(15) <b>Time-limited psychotherapies.</b> In time-limited psychotherapies, therapist and patient determine a goal in initial sessions and plan to spend a fixed number of sessions working on that goal (usually reduction of a symptom). Typically, the plan is for therapy to be brief: on the order of weeks or months. Compared to open-ended therapies, time-limited therapies have become popular because insurance companies are more likely to reimburse for them, and because their short duration makes them easier to manualize and test in RCTs.</p>
<p>(5) <b>Psychoanalysis.</b> The most intense form of open-ended psychodynamic psychotherapy. Practiced by psychoanalysts, who have trained for several years at a psychoanalytic training center. Meetings are three to five times weekly, with the patient often lying on a daybed (“couch”), and treatment often lasts several years. Compared with cognitive-behavioral therapies, there is exquisite attention to the therapist-patient relationship, and work on this relationship builds capacities for dealing better with other relationships. The analyst identifies problematic patterns unrecognized by the patient and helps the patient to resolve them. Goal is pervasive improvement of deeply-entrenched problems in thoughts, feelings, motivations, behaviors, and relationship patterns.</p>	<p>(11) <b>Transference-focused psychotherapy (TFP).</b> A twice-weekly manualized psychodynamic psychotherapy for severe personality disorders developed by Otto Kernberg et al at Cornell. RCT demonstrates efficacy equal to DBT at one year. Its creators claim it will be superior if compared to DBT after more treatment .</p>	
<p>(6) <b>Open-ended psychoanalytic psychotherapy (“psychodynamic psychotherapy”).</b> Based on psychoanalytic theories and psychotherapy techniques. Goals are significant and broad change, but less pervasive than in psychoanalysis. Conducted by psychoanalysts or non-psychoanalysts who nevertheless have studied psychoanalytic concepts. Patient and therapist usually sit facing each other (i.e., no “couch”).</p>		

**(16) Not disorder-specific.** See (3).

**(17) Time-limited psychoanalytic treatments that are not disorder specific.** Psychodynamic researchers responded to the pressure for short-term treatment by adapting subsets of psychoanalytic theory and technique to brief, manualized treatments.

**(18) Time Limited Dynamic Psychotherapy (TLDP):** Pioneered by Hans Strupp and Jeffrey Binder at Vanderbilt and further developed by Hanna Levenson in San Francisco, this is the version of brief psychoanalytic psychotherapy taught in the this residency. The goal is to identify an unconscious dysfunctional relationship pattern (a “cyclical maladaptive pattern”) which is then resolved as the therapist helps the patient develop *insight* into the pattern, while also interacting with the patient in a manner intended to provide a *corrective emotional experience*.

**(19) Short Term Dynamic Psychotherapy (STDP):** Pioneered by David Malan in England, this psychotherapy lasts 30-40 sessions. The therapist identifies a mental problem (e.g., a man’s passive aggression toward his wife) and formulates it as a *defense* arising because of a negative feeling (e.g., guilt) is motivating the individual *not* to express an adaptive impulse (e.g., the impulse to assert). The defense (passive aggression) both hides the impulse (it involves passivity) and expresses the impulse (it involves aggression). The therapist helps the patient to see the same pattern emerging in the treatment relationship (e.g., passive aggressive toward the therapist) and links it to childhood experience. Insight helps the patient to relinquish the pattern.

**(20) Short Term Intensive Dynamic Psychotherapy (STIDP):** Developed by Habib Davnaloo, and carried further by Leigh McCullough Vaillant), this 5 to 40 session treatment involves a similar conceptualization to Malan’s, but the therapist vigorously confronts and interprets defenses until there is a breakthrough of true feeling.

**(21) Time-limited cognitive behavioral therapies that are not disorder specific:** Most cognitive-behavioral therapies are brief and many are explicitly time-limited. In these treatments, the therapist does not use a manual oriented to a particular disorder. Rather, she questions the patient to identify the problem that needs work and conceptualizes the problematic thoughts, feelings, and behaviors that need to be addressed.

**(22) Brief cognitive behavior therapies:** These brief psychotherapies employ both cognitive and behavioral techniques. See CBT handout for more detail.

**(23) Brief cognitive therapy:** In these brief therapies, therapist and patient use mostly cognitive techniques. See CBT handout for more.

**(24) Brief behavior therapy:** In these brief therapies, therapist and patient use mostly behavior techniques. See CBT handout for more detail

**(25) Time-limited, disorder-specific, RCT-tested treatments:** Compared with open-ended treatments, it has been much more possible to subject time-limited psychotherapies to RCTs. This is because they are easier to manualize, take less funding, have more circumscribed goals, and are short enough to minimize the obstacle of dropout.

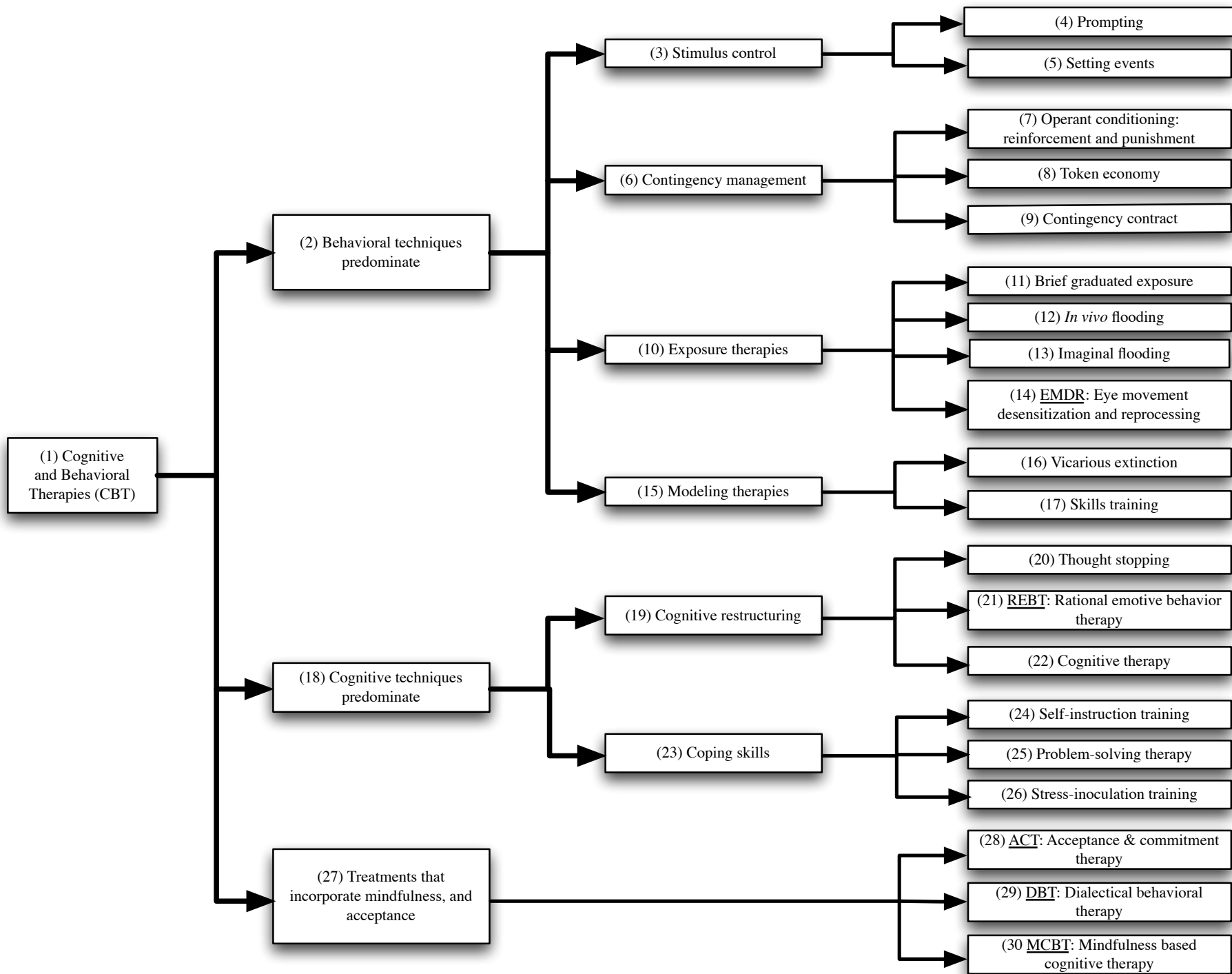
**(26) Time-limited, disorder-specific, RCT-tested psychodynamic treatments:** See attached table (from Gabbard, 2009) summarizing RCTs of psychodynamic treatments for various disorders.

**(27) Interpersonal Therapy (IPT):** Interpersonal psychotherapy is a time-limited (usually 16-week), dynamically informed psychotherapy. Its efficacy for depressive episodes has been empirically supported since the 1980s. It directly addresses issues in *interpersonal relationships*, such as grief and loss, role transitions, and interpersonal disputes. The therapist seeks to understand the therapist-patient relationship, but does not address it explicitly.

**(28) Time-limited, disorder-specific, RCT-tested CBT treatments:** See attached table (from Butler et al, 2006) summarizing RCTs of CBT treatments for various disorders.

**February 15, 2012**

**A family tree of cognitive and behavioral schools and therapies**



<p><b>(1) Cognitive and behavioral therapies</b> involve techniques that target conscious cognitions (thoughts and sometimes emotions), behaviors, and environment. Unlike psychodynamic therapies, they are relatively inattentive to unconscious experience or to motivation.</p>
<p><b>(2) Behavioral techniques</b> involve environmental manipulations and encouragement of new behaviors, which can indirectly affect cognitions.</p>
<p><b>(3) Stimulus Control:</b> These behavioral interventions focus on adjusting environmental factors that serve as <i>stimuli</i> for positive or negative behaviors.</p>
<p><b>(4) Prompting.</b> In prompting, deliberate attention is given to the environmental cues that might prompt a desired behavior. Prompts may be verbal (e.g., the individual is reminded to do the desired behavior at the appropriate time), environmental (e.g., posted notes to remind a diabetic person to check blood glucose), physical (e.g., teaching a blind child to feed himself), or behavioral (e.g., when a child acts out, it's time for a time out).</p>
<p><b>(5) Setting events.</b> This refers to changing the setting to reduce negative stimuli, e.g. closing a window shade to reduce distraction of a person with ADHD, reducing access to high caloric foods for a person trying to lose weight; reducing visits to places where one can smoke if one is trying to quit.</p>
<p><b>(6) Contingency management</b> refers to a category of interventions that are responsive to what a patient does in the moment. The goal is to promote adaptive responses and discourage maladaptive responses.</p>

<p><b>(7) Operant conditioning</b> includes use of consequences to promote adaptive behaviors and to discourage maladaptive ones. Responses to desired actions may involve taking away something unpleasant (<i>negative reinforcement</i>) or providing pleasant consequences (<i>reward or positive reinforcement</i>). Responses to undesirable actions may involve unpleasant consequences (positive punishment) or taking away something pleasant (negative punishment).</p>
<p><b>(8) Token Economy.</b> Token economies are systems that have been used in psychiatric hospitals, community treatment centers, and other group settings. Tokens (e.g., poker chips) are awarded for adaptive behaviors and taken away as a consequence for maladaptive behaviors.</p>
<p><b>(9) Contingency contracts</b> are written agreements about behavior, along with clearly specified rewards for following the agreement and negative consequences for failing to do so.</p>
<p><b>(10) Exposure therapies.</b> In exposure therapy, the patient is exposed to a feared stimulus in a controlled and planned way. The goal is to extinguish the fear response.</p>
<p><b>(11) Brief/graduated exposure therapies.</b> In these therapies, patients are exposed to a graded series of stimuli, starting with those that are only mildly anxiety provoking and progressing towards those that are highly anxiety-provoking. The mode of exposure may be to have the patient vividly imagine the stimulus (<i>imaginal exposure</i>), to reproduce it in virtual reality, to describe it vividly, or to introduce the actual stimulus (<i>in vivo exposure</i>). Gradual imaginal exposure paired with relaxation is called <i>systematic desensitization</i>. Also, exposures are often accompanied by <i>response prevention</i>: the patient is prevented from engaging in usual avoidance behavior.</p>

<p><b>(12) In vivo flooding.</b> In flooding therapies, the patient is exposed, for an extended period, to an anxiety-provoking stimulus, <i>flooding</i> him with anxiety while demonstrating that the feared result does not occur. <i>In vivo</i> flooding accomplishes flooding through <i>direct exposure</i> to feared stimuli. Examples include treatment of dirt phobias through prolonged exposure to dirt or treatment of height phobia through prolonged exposure to height.</p>
<p><b>(13) Imaginal flooding</b> accomplishes flooding by having the patient <i>imagine</i> the feared stimulus. It is used when recreation of the <i>actual</i> stimulus is not useful. For example, it may be used to re-confront military traumas, natural disasters, etc.</p>
<p><b>(14) Eye movement desensitization and reprocessing (EMDR):</b> In this controversial therapy, the patient visualizes a traumatic memory and an associated maladaptive belief while watching the therapist's finger moving, an activity hypothesized to neurologically process trauma. Once anxiety has been reduced in this way, the patient practices replacing a maladaptive belief (e.g., "I was so stupid not to run away") to an adaptive one (e.g., "I did everything I could.")</p>
<p><b>(15) Modeling therapies</b> involve a model who demonstrates an adaptive behavior and an observer who watches what the model does, as well as vicarious consequences. This is used to reduce anxiety and to teach skills.</p>
<p><b>(16) Vicarious extinction</b> involves the observer's fear being extinguished by watching a model perform a feared activity without negative consequence.</p>
<p><b>(17) Skills training</b> address skills deficits through packages of intervention including modeling, direct instruction, prompting, reinforcement, rehearsal, role playing, and feedback. Examples include training in assertiveness and other social skills.</p>

**(18) Cognitive techniques** target troubled cognitions (thoughts) directly, in contrast to behavioral techniques, which only indirectly affect cognition via changes in behavior and environment.

**(19) Cognitive restructuring** refers to a class of cognitive techniques that help patients to let go of distorted and erroneous cognitions that underlie problematic feelings.

**(20) Thought stopping** is a type of cognitive restructuring in which a person is taught to stop a persistent, intrusive, negative thought by thinking or saying “stop!” and substituting a preplanned adaptive competing thought.

**(21) Rational emotive behavior therapy (REBT)** is a cognitive restructuring therapy, created by Albert Ellis in the 1960s, that formulates disturbed feelings as arising not from the environment, but from the fact that a person’s response to the environment is based on irrational ways of thinking such as overgeneralization, absolute thinking, catastrophizing, an unreasonable sense of personal worthlessness, or an unreasonable sense of duty. REBT involves the therapist confronting the patient by identifying irrational beliefs and then disputing them in an active, authoritative, and persuasive way so that the irrational thoughts are replaced with more rational, and less upsetting, thoughts. The therapist is thus a *model* of rational thinking for the patient.

**(22) Cognitive therapy (CT)** is a cognitive restructuring treatment that was developed by Aaron Beck at the University of Pennsylvania and has been furthered by the work of his daughter Judith Beck, as well as others. Like REBT, cognitive therapy attempts to change distorted cognitions. However, the approach is different. Rather than being an authoritative model of rationality, the CT therapist strives for a *collaborative empiricism*, in which she uses Socratic questioning to collaborate with the patient in empirically testing his natural way of thinking (his “*automatic thoughts*”) to see if they are accurate or distorted.

**(23) Coping skills therapies.** While cognitive restructuring deals with excess maladaptive thoughts, coping skills therapies deal with a *deficit of adaptive thoughts*.

**(24) Self-instructional training:** Developed by Donald Meichenbaum, this therapy teaches a person to cope effectively with difficult situations (e.g., a child might be taught to do homework). To start, the therapist performs the task while giving voice to the instructions she is giving herself as she does it. The patient first observes, then does the task as the therapist speaks the instructions, then does the task speaking his own instructions, then does the task whispering instructions, then does the task with no talking. Has been used for impulsivity, schizophrenic behavior, bulimia, poor body image, pain, poor assertion, leisure skills.

**(25) Problem solving therapy.** This therapy, developed by Thomas D’Zurilla, teaches patients to solve problems by the following rational process: (1) identify and describe the problem, (2) generate as many potential solutions as possible without filtering or judgment, (3) use judgment to choose the best solution, (4) implement and evaluate the success of the solution. This has been applied to stress, depression, agoraphobia, eating disorders, smoking, marital problems, child abuse, and more. Patients who learn this approach with one problem are thought to generalize it to other problems.

**(26) Stress inoculation training.** In this therapy, developed by Donald Meichenbaum, patients are taught to cope with stresses such as anxiety, panic, anger, depression, and physical ailments. The coping skills include (1) *progressive relaxation* to alleviate muscle tension; (2) *cognitive restructuring* to oppose negative thoughts (“look for the positive aspects of this situation”); (3) *self-instructions* to walk themselves through coping (“What’s the next thing I need to do?”); and *self-efficacy instructions* (“Keep it up. You’re doing great.”) These skills are rehearsed while visualizing and role playing the stressor.

**(27) Treatments that incorporate mindfulness and acceptance.** While treatments centered on cognitive and behavioral techniques seek to *reduce* problems, *acceptance* based therapies seek to teach patients to accept certain painful aspects of their experience as inevitable. This concept is tightly tied to *mindfulness*, a core Buddhist practice involving nonjudgmental attention to one’s moment-to-moment experience.

**(28) Acceptance and commitment therapy (ACT)** is a treatment in which clients learn to accept negative thoughts and feelings, which cannot be controlled, and to move from behavioral *inflexibility* which defeats pursuit of their values to behavioral *flexibility* which promotes a life worth living. The treatment targets six core processes that promote *inflexibility*: cognitive fusion, attachment to the conceptualized self, experiential avoidance, disconnection from the moment, unclear personal values, and inaction with respect to values.

**(29) Dialectical behavioral therapy (DBT)** is a treatment for borderline personality disorder developed by Marsha Linehan in Seattle. It posits that the need for change and for self-acceptance coexist in dialectical tension with each other, i.e., they are opposites in one sense, but both true in another. Individual weekly sessions focus on life-threatening and therapy-interfering behaviors. Weekly skills-training groups focus on mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance.

**(30) Mindfulness based cognitive therapy (MBCT)** is a brief, cost-effective treatment for major depression that integrates the mindfulness based stress reduction (MBSR) techniques developed by Jon Kabat-Zinn (University of Massachusetts) with cognitive techniques. Over eight sessions, patients are taught to be mindful of negative thoughts.

**February 22, 2011**

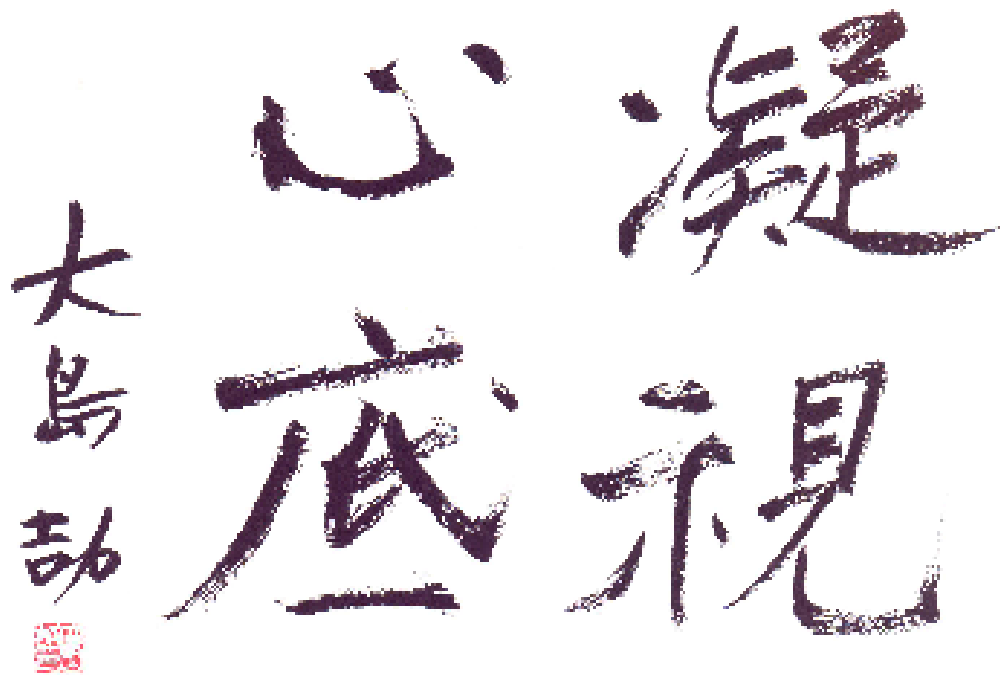
**Introduction to Psychoanalytic Psychotherapy**

**That Was Then, This is Now:**  
**Psychoanalytic Psychotherapy for the Rest of Us**

Jonathan Shedler, PhD  
Department of Psychiatry  
University of Colorado School of Medicine



Address correspondence to Jonathan Shedler, PhD, Department of Psychiatry, Mail Stop A011-04, 13001 East 17<sup>th</sup> Place, Aurora, CO 80045, or send email to [jonathan@shedler.com](mailto:jonathan@shedler.com)



"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  
April, 2010

## **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.<sup>1</sup>

---

<sup>1</sup> 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.<sup>2</sup>

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

---

<sup>2</sup> 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,"

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

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

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.<sup>3</sup>

### *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

---

<sup>3</sup> 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 19<sup>th</sup> 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.<sup>4</sup>

### *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.<sup>5</sup> 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

---

<sup>4</sup> 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.

<sup>5</sup> 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.

## Bibliography

- Ablon J.S. & Jones E.E. (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive-behavioral therapy. *Psychotherapy Research*, 8(1), 71-83.
- Bettelheim, B (1982). *Freud and Man's Soul: An Important Re-Interpretation of Freudian Theory*. NY: Random House.
- Bornstein, R. (1995). Psychoanalysis in the undergraduate curriculum: An agenda for the psychoanalytic researcher. Electronic publishing:  
<http://www.columbia.edu/~hc137/prs/v4n1/v4n1!2.htm>
- Bornstein, R. (2001). The impending death of psychoanalysis. *Psychoanalytic Psychology*, 18, 3-20.
- Brenner, C. (1994). The mind as conflict and compromise formation. *Journal of Clinical Psychoanalysis*, 3 (4), 473-488.
- Buirski, P. & Haglund, P. (2001). *Making Sense Together: The Intersubjective Approach to Psychotherapy*. NY: Jason Aronson.
- Davies, J.M. & Frawley, M.G. (1992). Dissociative processes and transference-countertransference paradigms in the psychoanalytically oriented treatment of adult survivors of childhood sexual abuse. *Psychoanalytic Dialogues*, 2, 1, 5-36.
- Freud, S. (1904). *The Psychopathology of Everyday Life*. SE 6
- Freud, S. (1912). *The Dynamics of Transference*. SE 12
- Gabbard G.O. (1992). Commentary on "Dissociative processes and transference-countertransference paradigms" by Jody Messler Davies and Mary Gail Frawley. *Psychoanalytic Dialogues*, 2, 1, 37-47.
- Gabbard, G., & Westen, D. (2003). Rethinking therapeutic action. *International Journal of Psycho-Analysis*. 84: 823-841.
- Gill, M. (1983). Psychoanalysis and psychotherapy: a revision. *International Review of Psychoanalysis*, 11, 161-179.
- Goldberger, M. (1995) The couch as defense and as potential for enactment. *Psychoanalytic Quarterly*, 64, 1, 23-42.
- Grigsby J. & Stevens, D. (2000). *Neurodynamics of Personality*. NY: Guilford.
- Hansell, J. (2005). Writing an undergraduate textbook: An analyst's strange journey. *Psychologist-Psychoanalyst*, 24, 4, 37-38. (Electronic publishing:  
<http://www.division39.org/pdfs/PsychPsychoanalyst1004c.pdf>)

- Jones, E.E. & Pulos, S.M. (1993). Comparing the process in psychodynamic and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology*, 61(2), 306-316.
- Kahneman, D. (2003). A Perspective on Judgment and Choice: Mapping Bounded Rationality. *American Psychologist*, 58, 9, 697-720.
- Kohlenberg, R. J. & Tsai, M. (1991). *Functional Analytic Psychotherapy: A guide for creating intense and curative therapeutic relationships*. New York: Plenum.
- Luepnitz D (2002). *Schopenhauer's Porcupines*. NY: Basic Books.
- McWilliams, N. (2004). *Psychoanalytic Psychotherapy: A Practitioner's Guide*. NY: Guilford.
- Persons, E.S, Cooper, A.M, & Gabbard, G.O. (2005). *Textbook of Psychoanalysis*. Washington, D.C.: American Psychiatric Publishing.
- Safran J.D. & Segal Z.V. (1990). *Interpersonal Process in Cognitive Therapy*. NY: Basic Books
- Safran J.D. (1998). *Widening the Scope of Cognitive Therapy: The Therapeutic Relationship, Emotion, and the Process of Change*. Northvale, NJ: Jason Aronson.
- [Shedler, J. \(2010\). The Efficacy of Psychodynamic Psychotherapy. \*American Psychologist\*, 65, 98-109.](#)
- Sullivan, H.S. (1954). *The Psychiatric Interview*. New York: Norton.
- Westen, D. (in press). Cognitive neuroscience and psychotherapy: Implications for psychotherapy's second century. In G. Gabbard, J. Beck, & J. Holmes (Eds.), *Oxford concise textbook of psychotherapy*. Oxford: Oxford University Press.
- Westen, D., and Gabbard, G. (2002a). Developments in cognitive neuroscience, 1: Conflict, compromise, and connectionism. *Journal of the American Psychoanalytic Association*, 50, 54-98.
- Westen, D., & Gabbard, G. (2002b). Developments in cognitive neuroscience, 2: Implications for the concept of transference. *Journal of the American Psychoanalytic Association*, 50, 99-133.
- Whitehorn, J.C., Braceland, F.J., Lippard, V.W., Malamud, W. (Eds.) (1953). *The Psychiatrist: His Training and Development*. Washington, DC: American Psychiatric Association.

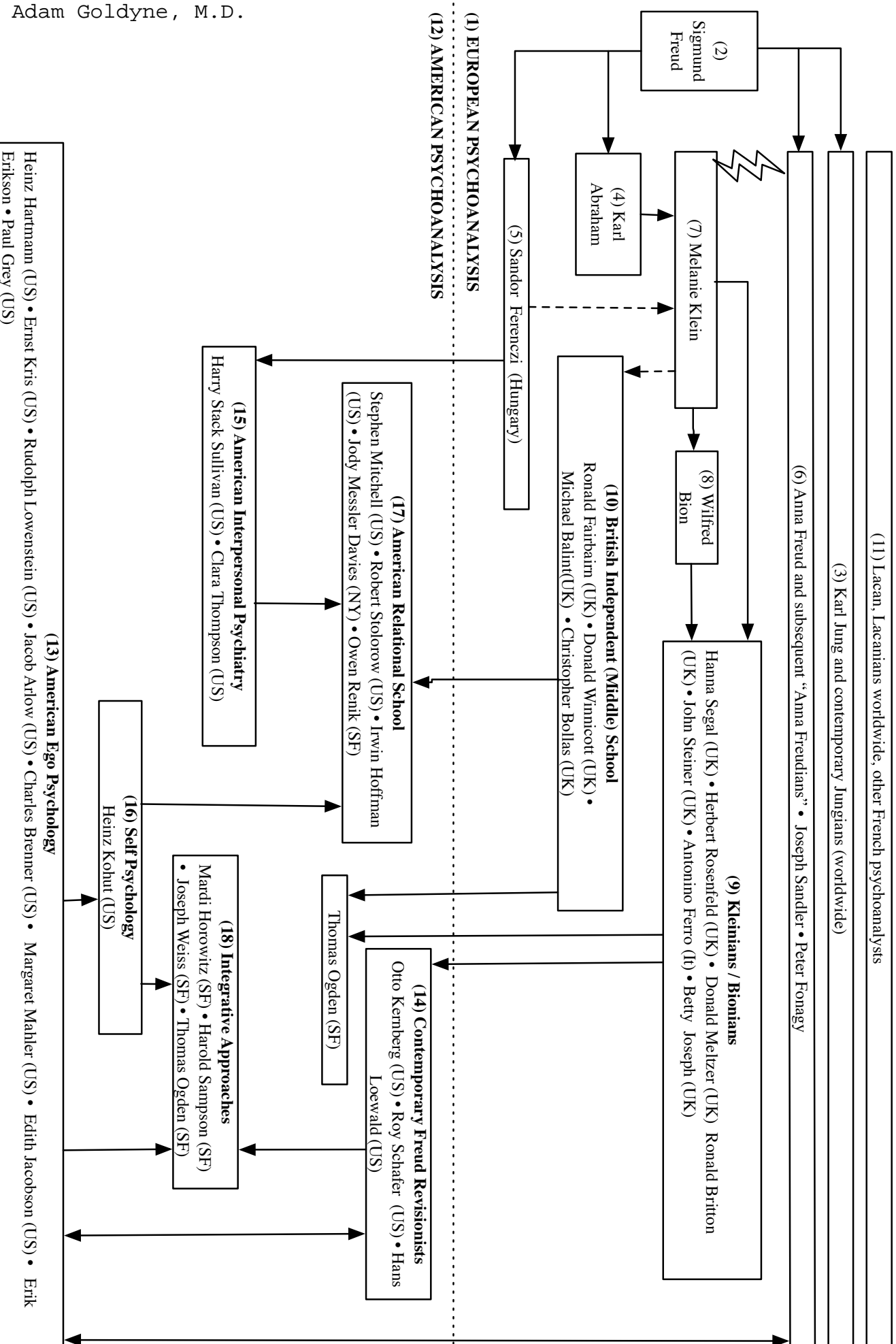
**February 29, 2012**

## **A “family tree” of psychoanalytic (psychodynamic) theorists and theories**

Recall that the “family tree” of cognitive and behavioral schools addressed various approaches to treatment. The various CBT approaches are relatively discrete and separable, consistent with the positivist spirit in which most of them were developed. As such, they are relatively straightforward to grasp, even with little background.

By contrast, the overview of psychoanalysis is mostly about the people and groups that have been important in the field over the last 120 years. Psychodynamic approaches are a mix of many different facets, including: (1) view of motivation, (2) idea of how genetics contribute to mental development, (3) ideas about how child-rearing contributes to mental development, (4) theories about what mental health is, (5) ideas about how mental problems work, (6) ideas about the kind of relationship one should provide in treatment, (7) ideas of what cures in psychoanalysis. All these facets intertwine and psychoanalytic ideas about how they work are subtle. Unlike CBT, thinking about psychoanalytic ideas requires a major frame-shift from other kinds of medical thinking.

Thus, if you are approaching these diagrams for the first time, you can expect to come away with a reasonable overview of CBT. On the other hand, if you know little about psychoanalysis, simply try to get an overall sense of who the major theorists and schools have been, where they lived, and what some of their major ideas are. Later in residency, we will devote multiple classes to delving more deeply into psychoanalytic ideas.



## (1) European Psychoanalysis

psychoanalysis as a whole had roots in Vienna with Freud • less conservative than in the US • less tied to medicine & psychiatry than in US • flourishing today throughout Europe

(2) **Sigmund Freud** • spent most of career in Vienna • pioneered psychoanalysis • conscious experience determined by unconscious experience • we avoid awareness of painful feelings by using defense mechanisms • patient's view of the therapist is shaped by past (transference) • patient's job in analysis is to free associate • analyst's job is to understand unconscious roots of patient's problem and explain (interpret) this understanding to patient • therapist's feelings can be affected by the patient ("countertransference"), but this is a distraction in treatment • therapist abstains from personal interactions with patient (e.g., self disclosure) because it interferes with understanding and interpreting • called mental representations of people "objects" • he called the mind's way of processing objects "object relations"

(3) **Karl Jung** • lived in Switzerland • Freud's original "crown prince" • broke with Freud, whom he considered focused too much on sex and not enough on religion • Jungian analysis has been a separate tradition since, with worldwide institutes • ideas about personality types (e.g., introversion and extraversion) are widely known • ideas influenced psychological instruments such as Myers-Briggs

(4) **Karl Abraham** • Germany • analyzed & collaborated with Freud • developed Freud's ideas about personality development • was Klein's analyst • many resonances of his ideas in Kleinian thought

(5) **Sandor Ferenczi** • Hungarian • worked with traumatized, disturbed patients • experimented with boundaries (mutual analysis, self) • from contemporary perspective, violated boundaries • major influence on analysts from the British Independent School (Balint) and American Relational Schools who have experimented with more loosening of boundaries in psychoanalysis (self disclosing, etc) • was Klein's analyst, but her ideas are closer to those of her other analyst, Abraham

(6) **Anna Freud & followers** • Sigmund's daughter • moved with Sigmund from Vienna to London in 1930s • child analyst • major work on defense mechanisms & child development • ideas clashed with Melanie Klein's • **Joseph Sandler** • in UK • extended A. Freud's work • took up how people affect each other via *role responsiveness* • **Peter Fonagy** • influenced by Anna Freud, Sandler, Independents, & Attachment Theory • instrumental in exploring evidence base for psychotherapy & critically evaluating different psychoanalytic theories • impressive RCT: Mentalization Based Therapy (MBT) for borderline personality

(7) **Melanie Klein** • started in Berlin, but moved to London in 1920s. • analyzed by both Ferenczi and Abraham • ideas clashed with Anna Freud's, resulting in the British Psychoanalytical Society splitting into Kleinians, (Anna) Freudians, & an Independent (Middle) school of British psychoanalysis • pioneered new ways to think about and work with children and very disturbed patients • pioneered idea that people are wired for relationships • major contributions to object relations theory

(8) **Wilfred Bion** • analyzed by Klein • major theories about groups • major object relations theorist • extended Klein's theory of projective identification to explain how people can communicate their feelings with each other unconsciously • brilliant hypothesis that psychotic thought disorder comes from a person shutting down mental functioning to defend against painful feelings • proposed that children grow by experiencing and internalizing a parent's ability to register

(9) **Kleinian / Bionians** • sometimes called "contemporary Kleinians" or "Neo-Kleinian" • major object relations theorists • extended thinking of Klein and Bion, some emphasizing Klein more, others emphasizing Bion more • major contributions to how to understand and help people with primitive experiences (psychosis & severe personality disorders) in psychoanalysis • use the concept of projective identification to understand transference / countertransference • major focus on countertransference and acting out and careful focus on the here-and-now therapeutic relationship • mostly in London, but also in South America (e.g., Racker), Italy (Ferro, an Italian Bionian), and US (Ogden, who bridges Kleinian/Bionian and Independent thinking). Particularly popular in Los Angeles (where Bion lived for years) and San Francisco.

(10) **British Independent School**: sometimes called the British Middle School • sometimes called the British "object relations" school • grew out of the group of British psychoanalysts who did not want to commit to be either Anna Freudian or Kleinian when the British Psychoanalytic Society split in 1944 • influenced by Klein's description of the importance of self/other representations (objects) in the mind • as a group, these analysts have a less coherent theoretical focus than Freudians or Kleinians • focus on how early childhood parent-child relationship shapes people • children are genetically disposed to healthy development, but pathology arises from parental abuse, neglect, or misattunement

**William R.D. Fairbairn** (writing 1930s-60s) • provided an account of development, health, and illness having nothing to do with Freud's drives

**Donald Winnicott** (writing in 1940s - 60s) • was a pediatrician / psychoanalyst • analyzed by Klein • one of most important analytic theorists ever • described how parent-child bond affects development • importance of playing, transitional objects, mirroring, true self, false self, and many other critical concepts

**Michael Balint** • analyzed by Ferenczi • believed that problematic parenting introduced a *basic fault* into the personality • analysis cures through unconditional love that was missing in childhood.

**(11) French Psychoanalysis • Jaques Lacan** • synthesized psychoanalytic theory with linguistics • viewed the ego as “imaginary” and called for a purer focus on Freud’s topographical model (conscious, preconscious, unconscious) • Lacanian institutes worldwide • very influential in South America • **Andre Green** • influenced by Winnicott • focus on creativity and growth versus despair and non-existence

### **(12) American Psychoanalysis**

imported in 1930s • for many years was much more conservative than in Europe, retaining Freud’s structural theory (ego, id, superego) much more fervently than in Europe • very medical: dominant in psychiatry until 1970s and didn’t train psychologists until 1980s, after psychologists sued the American Psychoanalytic Association

**(13) Ego psychology** • American “classical” psychoanalysis • made fun of in *New Yorker* and Woody Allen movies • dominated psychiatry from 1950s-70s • closely related to Anna Freud in England • focus on structural model: ego, id, superego

**Ego psychology pioneers** • **Ernst Kris** • trained in Vienna, moved to NY • wrote in 40s and 50s • pioneered treatment with careful attention to the ego, rather than the id • **Heinz Hartmann** • analyzed by Freud • developed a psychoanalytic view of normal and *conflict free* aspects of the ego

**Developmental ego psychology** • **René Spitz** • Born in Vienna, moved to NY • observed orphans who were fed, but not nurtured, and failed to thrive • undertook infant-mother research • research was critical in showing importance of early child-rearing in mental development • **Margaret Mahler** • trained in Vienna and moved to NY • offered psychoanalytic account of infant development based on infant observation • **Edith Jacobson** • Trained in Berlin and escaped Nazis to come to US • provided an account of development that incorporated drives, child-rearing, and object relations • **Erik Erikson** • in San Francisco • described how culture & drives create eight stages of mental development • described the development of a sense of identity

**(14) Contemporary Freudian Revisionists** • strike a balance between altering and preserving Freud’s concepts • **Otto Kernberg** trained in Uruguay, now in NY • writing since 1960s • pioneer of understanding and working with borderline patients • developer of manualized Transference Focused Therapy (TFP) for borderline patients • clashed with Kohut over theory of narcissism • Integrates Kleinian theory, ego psychology, and Jacobson’s work • **Roy Schafer** • in NY • instrumental in bringing Kleinian theory to the United States • views psychoanalysis as about constructing narrative, rather than establishing scientific truth

**(15) Interpersonal Psychoanalysis** • **Harry Stack Sullivan** • worked in US with schizophrenic patients, starting in 1920s • focused on interpersonal interactions in the “here and now,” rather than uncovering drives and reconstructing the past • much like the Kleinians and independents in England • **Clara Thompson** • Trained in NY • analyzed in Budapest by Ferenczi • emphasized the importance of interpersonal relationships

**(16) Self Psychology** • **Heinz Kohut** • emigrated from Vienna to Chicago • spent most of his career as an ego psychologist • developed self psychology in 1960s and 1970s • grew out of ego psychology • believed that mental disorders grew out of inadequate empathy from parents, resulting in a defective sense of self • clashed with Kernberg over theory of narcissism • analyst helps patient by becoming a *selfobject*: a deeply empathic person who recognizes the patient’s internal states (*mirroring*), becomes an object for the patient to idealize, and allows the patient to be nurtured by the sense that he and the analyst are alike (*the twinship transference*)

**(17) American Relational / Intersubjective Psychoanalysis** • **Stephen Mitchell** • NY • with Greenberg, wrote *Object Relations in Psychoanalytic Theory* • pulled together notion of relationships as central in multiple schools: Freud, Klein, Winnicott, Fairbairn, Kohut, Interpersonal Psychoanalysis etc • built a new school of relational psychoanalysis • **Robert Stolorow** • built on Kohut’s work • founded intersubjectivity theory: considers full mutual interaction between two subjectivities • **Irwin Hoffman (Chicago)**, **Jody Messler Davies (NY)**, **Owen Renik (SF)**, and others have experimented with self-disclosure and other alterations in technique.

**(18) Integrative approaches** • Integrate various psychoanalytic concepts with concepts from other streams • **Mardi Horowitz** • in San Francisco • approach to formulation that integrates cognitive psychology with several aspects of psychoanalytic theory — ego psychology, self psychology, object relations theorists (e.g., Kernberg • **Harold Sampson and Joseph Weiss** • developed **Control Mastery Theory** • theory derived from psychotherapy research conducted by San Francisco Psychotherapy Research Group • integrates psychoanalytic concepts with cognitive concepts • has empirically tested their concepts • **Thomas Ogden** • San Francisco analyst • major integration of the ideas of Klein, Bion, and Winnicott.