Chapter 1

What Defines a Psychoanalytic Therapy?

> We must not forget that the analytic relationship is based on a love of truth—that is, on a recognition of reality—and that it precludes any kind of sham or deceit.
>
> —SIGMUND FREUD (1937, p. 248)

Psychoanalytic therapies, including psychoanalysis, are approaches to helping people that derive ultimately from the ideas of Sigmund Freud and his collaborators and followers. Perhaps such a genealogy could be claimed for almost all versions of the "talking cure," as most types of therapeutic encounter—even those that differ rather dramatically from Freud's way of working—have at least a distant connection with his influence.

It seems to me that the overarching theme among psychodynamic approaches to helping people is that the more honest we are with ourselves, the better our chances for living a satisfying and useful life. Moreover, a psychoanalytic sensibility appreciates the fact that honesty about our own motives does not come easily to us. The diverse therapeutic approaches within the psychoanalytic pantheon share the aim of cultivating an increased capacity to acknowledge what is not conscious—that is, to admit what is difficult or painful to see in ourselves. Unconscious phenomena may include a sense of weakness (risk of psychic decompensation, fragmentation, annihilation), vanity (vulnerability to shame, aspirations to perfection, fantasies of omnipotence, specialness, and entitlement), conflict (tensions between wishes and prohibitions, ambivalence, pursuit of mutually exclusive aims), moral deficit (self-deception, temptations to be self-righteous, blindness to negative consequences of actions), or the lust, greed, competition, and aggres-

sion that early Freudian theory unmasked so enthusiastically in the climate of a society considerably more decorous than the one we now inhabit.

Psychoanalytic clinical and theoretical writing has always specialized in exposing motives that are not obvious to us, on the premise that becoming aware of disavowed aspects of our psychologies will relieve us of the time and effort required to keep them unconscious. Thus, more of our attention and energy can be liberated for the complex task of living realistically, productively, and joyfully. Motives that tend to be relegated to unconsciousness vary from individual to individual, from culture to culture, and from one time period to another. It is probably no accident that in contemporary Western cultures, where individual mobility is assumed, where extended and even nuclear families are geographically disparate, and where the assumed solution to most relationship problems is separation—in other words, where longings to cling are unwelcome and signs of dependency inspire scorn—psychoanalytic researchers and theorists are emphasizing attachment, relationship, mutuality, and intersubjectivity.

If this account sounds somewhat moralistic, that is also not accidental. Several decades ago, the sociologist Philip Rieff made a scholarly and persuasive argument that Freud was essentially a moralist—not in the popular sense of the person who gets a rush from attacking others for engaging in specific sins, but in the more philosophical sense of being ultimately concerned with what is true:

> The tension between instinctual candor and cultural hypocrisy . . . must be acknowledged; the act of doing so describes for Freud the beginning of new health. . . . Psychoanalysis . . . demands a special capacity for candor which not only distinguishes it as a healing movement but also connects it with the drive toward disenchantment characteristic of modern literature and of life among the intellectuals. (1959, p. 315)

As Michael Guy Thompson (2002) and others inheritors of Rieff's perspective have argued, psychoanalysis as a field has, whatever its lapses from that ideal, embraced an ethic of honesty that takes precedence over other aims and regards therapeutic goals, including symptom relief, as by-products of the achievement of honest discourse. Thomas Szasz (2003) has gone so far as to as to define psychoanalysis as "*a moral dialogue, not a medical treatment*" (p. 46). For many decades, the ethic of honesty was personified in the image of a therapist who had presumably attained unflinching self-awareness in a personal analysis and who bore the responsibility for fostering the same achievement in

the patient. In current analytic writing, there is more acknowledgment that participation in a therapeutic partnership requires *both* analyst and patient to become progressively more honest with themselves in the context of that relationship.

Bion (1970) observed that psychoanalysis is located at the intersection of two vertices: the medical and the religious (cf. Strenger, 1991). By "medical," he referred to the more objective, rational, technocratic, authoritative stance of the person trying to offer practical help to those suffering from mental and emotional disorders. The medical vertex is characterized by validated techniques, applied by an expert, intended to have specific, replicable effects. Recent efforts of Kernberg and his colleagues (e.g., Yeomans, Clarkin, & Kernberg, 2002) to develop manualized treatments for borderline personality organization exemplify this face of psychodynamic practice. Current writing on the neurology and brain chemistry of subjectivity and the changes that occur in analytic therapy (e.g., Schore, 1994, 2003a, 2003b; Solms & Turnbull, 2002) also belong to the medical axis. In noting the equally important "religious" vertex, Bion was calling attention to a dimension that is often labeled as existential, experiential, humanistic, romantic, collaborative, or discovery-oriented ways of seeking answers to (unanswerable) human questions.

Described empirically, approaches that have been labeled psychodynamic, at least in the short-term therapy literature, have a number of overlapping aspects. Blagys and Hilsenroth (2000), in an extensive review of the comparative psychotherapy process literature that examined replicated data across several studies, identified seven factors distinguishing psychodynamic from cognitive-behavioral treatments. The psychodynamic therapies were characterized by (1) focus on affect and the expression of emotion; (2) exploration of the patient's efforts to avoid certain topics or engage in activities that retard therapeutic progress (i.e., work with resistance); (3) identification of patterns in the patient's actions, thoughts, feelings, experiences, and relationships (object relations); (4) emphasis on past experiences; (5) focus on interpersonal experiences; (6) emphasis on the therapeutic relationship (transference and the working alliance); and (7) explorations of wishes, dreams, and fantasies (intrapsychic dynamics). The researchers noted that such differences are not categorical—they are not "present" versus "not present"; rather, they are dimensional. Hilsenroth (personal communication, June 22, 2003) compares such distinctions to a light with a dimmer switch instead of an on/off button; that is, they are employed significantly more by adherents of one philosophy of treatment. Thus, some of the features he and Blagys extracted (e.g., item 3) are shared by cognitive-behavioral practitioners, while some others (e.g., item 2) are not always features of psychodynamic practice—

for example, in the work of therapists with a self psychology orientation or of those with a traditional ego-psychology view when treating clients they see as needing supportive rather than exploratory therapy.

I believe that what most practicing analytic therapists see as distinctive about the psychodynamic therapies (including psychoanalysis), what differentiates them from cognitive-behavioral and other nonpsychoanalytic treatments, is not a matter of "technique"—that is, how frequently the person is seen, whether free association is encouraged, whether the therapist remains relatively quiet, whether the two participants talk about the patient's childhood, or even whether the therapist explicitly addresses transference reactions—but is instead the nature of the assumptions that underlie the therapist's activity. There is a certain mental set infusing psychodynamic thinking and practice. It is hard to describe, partly because it appreciates nonverbal and preverbal experience, but (as Justice Potter Stewart memorably quipped about a rather different topic) one knows it when one sees it. I will try to sketch it out in this chapter and the next by reference to several related topics.

Contemporary psychoanalytic scholarship has included increasingly frank attention to human spiritual needs and strivings (e.g., Gordon, in press; Lawner, 2001; Roland, 1999). Bion did not go so far as to say so, but it is arguable that there is a rather substantial "theology" shared by psychoanalytic practitioners.[1] Among its articles of faith are, as noted earlier, the belief that knowing oneself deeply will have complex positive effects; that being honest (relinquishing defensiveness or replacing the false self with authenticity) is central to health and especially to mental health; and that the best preparation for doing analytic therapy is to undergo analytic therapy. In Chapter 2 I elaborate on this implicit belief system or overarching sensibility. Before going there, let me detour into psychoanalytic history to consider why so many people equate the psychoanalytic tradition with only one vertex, the one Bion called medical, and why, even within that vertex, they wrongly associate it with a narrowly defined version of therapy. My comments in the next section apply mostly to the United States, but given the subtle and pervasive ways that American attitudes can infiltrate or have unintended effects on other cultures, they may be of interest to readers in other parts of the world.

BACKGROUND INFORMATION

The Evolution of a "Classical" Psychoanalytic Technique

When psychoanalytic theory migrated across the Atlantic Ocean in the early part of the twentieth century, North American medicine was held

in rather low esteem. Antibiotics had not been discovered, life expectancy was in the forties, a distressing number of women died in childbirth, twenty-five percent of children died in infancy, and doctors were regarded more as hand-holders than as miracle workers. Because medical training had not been standardized, many people practiced as physicians with certifications from diploma mills of dubious quality. In 1910, the Carnegie Foundation issued the infamous Flexner Report, describing the low and inconsistent standards that characterized American medical training. Wallerstein (1998) notes that by 1930, the effect of this exposé was a radical retrenching of training along the lines of a model that originated at Johns Hopkins: "The watchword was to exorcize the charlatans from the therapeutic activity and to make the proper medical degree, from the now fully upgraded schools, the hallmark of proper training and competence in the healing arts" (p. 5). Given their post-Flexner sensitivity to accusations of shabby standards, American doctors who became interested in psychoanalysis were determined that it not become viewed as a faddish, unscientific activity. They wanted to specify the technical procedures that defined it as a medical specialty.

Freud felt strongly that psychoanalysis should not be a strictly medical specialty, and eventually argued at length (1926) that the ideal preparation for doing psychoanalysis is the broadest possible grounding in history, literature, the social sciences, psychology, and the humanities, plus a personal analysis. A number of his most cherished analytic colleagues were not physicians, and although his own medical standing was a matter of great importance to him, he did not want to see psychoanalysis become "the handmaiden of psychiatry." Despite the fact that in one famous passage he compared analysis to surgery, he clearly saw it as something that could not be defined by an invariant technique, and he said so many times.

In the years when the Flexner report was disturbing American physicians, however, Freud was becoming increasingly troubled by reckless and misguided applications of his ideas. Self-described analysts were springing up, claiming expertise despite a lack of personal analysis or psychoanalytic training. And people were taking his name in vain. For example, he learned that a neighboring doctor, citing his work, had told a patient that her neurotic symptoms would vanish if only she would get a sex life. He was also becoming distressed to learn that some analysts were rationalizing sexual contact with patients. Understandably, he became concerned about what he called "wild" psychoanalysis, fearing that his cherished movement would be tarred with the brush of quackery. Freud appealed to readers to oppose glib impositions of his concepts, insisting that

> It is not enough . . . for a physician to know a few of the findings of psycho-analysis; he must also have familiarized himself with its technique if he wishes his medical procedure to be guided by a psychoanalytic point of view. This technique cannot yet be learnt from books, and it certainly cannot be discovered independently without great sacrifices of time, labour and success. Like other medical techniques, it is to be learnt from those who are already proficient in it. (1910, p. 226)

(It should be noted that at this point, the procedures Freud was recommending were designed to address only what were then called the "neuroses"—that is, hysterical conditions, obsessions and compulsions, phobias, and nonpsychotic depressions. Hence, technique could be characterized as more or less consistent across the problems for which analytic treatment had been devised. When psychoses, personality disorders, borderline states, posttraumatic conditions, addictions, and other nonneurotic problems were taken up, they naturally called for different approaches.)

Shortly after his 1910 article, as Freud writing his definitive papers on technique, which were to become standard psychoanalytic practice (Freud, 1912a, 1912b, 1913, 1915), he was stressed to learn that some of his colleagues were having sexual relations with their patients. Before therapists became aware of how powerful a phenomenon transference is, it was perhaps not that obvious to would-be analysts that an affair with a patient would be considerably more destructive than a sexual connection that might develop between any two people in a professional relationship for example, between an adult woman and her dentist or accountant. Consequently, Freud's comments on technique emphasize discipline and restraint and warn emphatically against exploiting feelings that may arise in treatment.

Mark Siegert (personal communication, November 12,2003) suggests that in addition to worrying about the bad judgment shown by some of his colleagues, Freud was feeling defensive in the face of the accusations then being aimed at his ideas. His critics charged that rather than finding evidence in his patients of infantile sexual preoccupations, he was putting his ideas about sexuality into their heads. (This argument is strikingly similar, and probably involves a comparable patient population, to the contemporary concern among many thoughtful professionals that dissociative reactions and traumatic memories may be created iatrogenically by overly enthusiastic practitioners finding in their clients what they are already sure is there.) In response to such criticisms, it is understandable that Freud put so much emphasis on being neutral and avoiding all efforts to influence the patient's free associations.

The convergence of these concerns—the determination of American physicians to establish their scientific respectability, the impact of Freud's worry about irresponsible applications of his ideas, and a general determination on the part of Freud and others not to give ammunition to critics of the psychoanalytic movement—led to an effort by the American medical community to control analytic training and to define psychoanalysis *as a medical procedure*, a procedure as standardized as accepted surgical methods. There is an art to surgery, and it was understood that there is also an art to psychotherapy. But the accent was on uniformity of method, exactitude, and the systematic elaboration of the patient's psychology in the context of the analyst's neutrality, objectivity, and abstinence from gratifying any longing of the patient other than the wish for self-understanding. These emphases reflect the scientific values of the Enlightenment, with its idealization of the dispassionate scientist and its emphasis on freeing the rational from the irrational.

Some Consequences of the American Medicalization of Psychoanalysis

In the United States, until a 1986 lawsuit (*Welch v. the American Psychoanalytic Association*) opened the doors of all analytic institutes to nonmedical practitioners, most respected American psychoanalytic organizations were dominated by psychiatrists, who admitted psychologists and other "lay" professionals to their training programs only on the condition that they agree to use their psychoanalytic education for research rather than practice.[2] A benefit of the effort to claim psychoanalysis as a technical medical specialty rather than an interdisciplinary body of knowledge and praxis (Berger, 2002) was, given the vastly increased status of medicine in the postantibiotic age, that psychoanalysis piggybacked on the standing of medicine in general. Being a psychoanalyst became highly prestigious. Doctors who wanted to practice psychotherapy could do so with the confidence that they would be well regarded and well paid. Patients knew that in seeking analysis from someone affiliated with the American Psychoanalytic Association, they would be treated by a person with at least enough intelligence and sanity to get through medical school. It is also probable that a considerable amount of "wild" analysis was thereby prevented.

In addition, as it became common for people to cover their medical expenses via indemnity insurance, the definition of psychotherapy as a medical specialty permitted it to be eligible for third-party reimbursement. During World War II, when psychologists were recruited to do psychotherapy, it was not lost on them that they were doing the

same work as psychiatrists. Soon they began establishing the doctorate as the preferable degree for practice as psychologist-therapists, and when they campaigned for licensing and inclusion in insurance plans, they argued "We're doctors, too!" Thus, the association between psychotherapy and medical science worked to the economic benefit not just of psychiatrists but also of psychologists.[3]

The costs of redefining psychoanalysis as a technical procedure comparable to surgery, however, have been steep. First, construing it this way contributed to the relative isolation of psychoanalysis in medical schools and free-standing institutes. This segregation reduced opportunities for analysts to learn from intellectuals outside their field and for other intellectuals to learn from psychoanalysts. It also conduced to a somewhat cult-like atmosphere in psychoanalytic training centers. Except in New York and a few other cities where analysts participated in university life, most undergraduate and graduate professors (other than those in medical schools) had no way of staying in touch with controversies and changes in psychoanalytic theory and practice. What they knew tended to come from intellectual familiarity with some of Freud's theories, or from their own experience as patients, or from the way analysis was portrayed by medical spokespersons or the media. Even today, it is common for authors of academic textbooks on personality and psychopathology to dismiss the psychodynamic tradition based on their reading of a small amount of literature from decades ago. One would never know from academic representations that psychoanalysis remains vital, regularly generating new paradigms that reflect advances in research, assimilation of different philosophical positions, exposure to non-Western cultural attitudes, and appreciation of new scientific theories.

Second, because of its high status as medical expertise, psychoanalytic training became greatly appealing to some professionals whose needs for prestige and recognition were more powerful than their wish to help or their feeling for others. In fact, it is probably not too much of a stretch to describe traditional psychoanalytic institutes, in what some have called the "halcyon years" of analytic preeminence in psychiatry, as magnets for narcissists. The education that took place in institutes became more than usually contaminated by narcissistically related processes such as idealization, splitting, envy, and punishment for those who fail to mirror the biases of their teachers (Kernberg, 1986, 2000; Kirsner, 2000). The sense of self-importance in some analysts in the mid- to late-twentieth century has been painfully evident and bears considerable responsibility for negative reactions to the psychodynamic tradition. According to Good's (2001) report of the findings of an American Psychoanalytic Association marketing task force, "We found

out that other mental health professionals actually knew a lot more about psychoanalysis and psychoanalysts than we anticipated. We learned it wasn't so much that they didn't like psychoanalysis as that they didn't like *us*" (pp. 1, 6).

Third, the presumption that psychoanalytic treatment possesses medically demonstrated effectiveness contributed to the disinclination of many analysts to subject their ideas to conventional scientific investigation. Although there is much more empirical research on psychoanalysis and psychodynamic therapy than insurers, drug companies, and some academics like to acknowledge—Masling (2000, quoted in L. Hoffman, 2002) estimates that there are over five thousand empirical studies based on psychodynamic ideas—there is much less research on therapy outcome than there ought to be. Freud bears some responsibility for a dismissive attitude toward empirical research. Once when Saul Rosenzweig, an American psychologist, wrote to him saying that his ideas about repression had been validated in the laboratory, Freud's response was that his own evidence for repression had been sufficient; he considered the empirical testing of the concept gratuitous.

Partly, the disinclination of psychoanalytic therapists since Freud to conduct research is an issue of temperament: Few people who are attracted to the holistic, European philosophical traditions are interested in running carefully controlled studies. They tend to be introverted, introspective, and skeptical about what can be operationalized without distorting the phenomenon under consideration. People who want to be healers are more interested in being out in the imperfectly controlled world trying to help people. Partly, the disinclination to conduct empirical studies on psychotherapy outcome may have expressed a conviction about the value of psychoanalysis that comes from one's personal experiences as both patient and therapist—a conviction that can make conventional empirical evidence seem unnecessary or superfluous. But analysts' resistance to having their beliefs examined through the lens of the researcher also had something to do with the complacency that goes with being an elite. And in the current political climate in the United States, analytic practitioners are paying a high price for not having done more to subject psychoanalytic therapies to controlled investigation.

Fourth, the prestige commanded by psychoanalysis in its so-called heyday ensured that its language would be coopted in the service of very conventional social norms. For example, far too many American women were told by practitioners that they suffered from penis envy—not in the tone of a compassionate revelation that we all suffer primordial, inescapable envious feelings for anything we lack (breasts, child-bearing capacity, fertility, youth, riches, beauty, power, talent,

health . . .) but with the implication that any ambitions they had beyond being middle-class housewives and mothers were pathological. A kind of pedestrian violence was done to the radical, unconventional, tragic psychoanalytic message about unconscious desire in an effort to enforce conformity, to tame and sanitize the soul rather than to plumb it. The European psychoanalytic sensibility actually grafts rather badly on to mainstream American attitudes; there is nothing in it that inherently values conformity or supports materialistic striving or equates the "pursuit of happiness" with the bustle of commerce, the expansion of markets, the assumption that scientific and technological progress will resolve perennial human predicaments. In fact, as M. Thompson observes (2002), because of its insistence on talking frankly about phenomena that one's culture prefers to ignore, "psychoanalysis is unremittingly subversive" (p. 82).

Fifth, and most important from the perspective of this book, American psychoanalytic clinical practice in the mid-twentieth century became closely associated with the version of analysis that was regarded as standard technique within mainstream, medically dominated training institutes. Despite the fact that Glover's (1955) midcentury survey of analysts showed striking disparities in how they actually practiced, the felt need to articulate a prototypical procedure was strong. In the United States, many were distressed by the innovations of Franz Alexander (L. Stone, 1961), who construed psychoanalytic treatment as a "corrective emotional experience," a notion that they saw as opening the door to manipulative ways of working with patients. A conservative paper by Kurt Eissler (1953) on "basic model technique," which acknowledged a need for "parameters" in some treatments but specified very narrow conditions for deviating from standard technique, was received as a welcome antidote to Alexander's innovations. Within psychiatry, what Lohser and Newton (1996) have called "a neo-orthodoxy that is mistakenly considered to be traditional" (p. 10) came to dominate practice. Bucci (2002) recently provided a succinct description of "orthodox" procedure: "Psychoanalytic treatment was defined in terms of adherence to standard techniques, focused on interpretation leading to insight in the context of the transference" (p. 217).

This "classical" technique invoked—rather selectively—Freud's reflections on how he personally had come to conduct treatment. Freud's ideas are notable for their tone of flexibility and respect for individual differences, but they were condensed into a set of "rules" that supervisors handed down to trainees (e.g., "You never answer a patient's question; you explore it" and "Always analyze; never gratify" and "Coming late must be interpreted as resistance" and "You can't tell the patient

anything about yourself"). Herbert Schlesinger (2003) writes of his own experience of psychoanalytic training in the 1950s:

> Perhaps most analysts were introduced to the mysteries of psychoanalytic technique as I was: that it was not so much a cohesive body of structured knowledge and practice as a loose collection of do's and don'ts. A chill in the heart warned me that to violate any one of them would ruin the analysis. (p. 1)

It has been my observation that the worst offenders in terms of defining psychoanalytic therapy as a list of unbreakable do's and don'ts have been practitioners without analytic training or extensive personal experience as analysands, who came of age professionally when psychoanalysis dominated psychiatry. Such clinicians have often had a stereotyped image of the way analysts practice and have affected all the trappings without the underlying substance of the tradition. What they represented, with the rationale that it was orthodox or classical, has always seemed to me a perversion of psychoanalytic practice (cf. Ghent's, 1990, illuminating argument that submission is the perversion of a healthy striving for the experience of surrender). Most fully trained and seasoned analysts, medically affiliated or not, have been—and have recommended being—considerably warmer, more natural, and more flexible than such "rules of technique" suggest. And so was Freud (Ellman, 1991; Lipton, 1977; M. Thompson, 1996).

It is not surprising that people who know the psychoanalytic tradition only from its caricatures as represented by untalented practitioners attracted to its status, or from nonanalysts identifying with their fantasy of a perfectly sterile medical technique, define it as the procedure in which the therapist says little beyond the occasional accusation that the patient is "resisting." It can also be confusing that Freud himself was inconsistent in how he defined it. When he was worried about people applying his concepts in a swashbuckling, undisciplined way, he tended to stress the care with which one applies a particular set of technical interventions. When he was being simply reflective about the essence of the process, he was known to say (e.g., 1914, p. 16) that any line of investigation in which transference and resistance are addressed can legitimately call itself psychoanalysis. In a 1906 letter to Carl Jung, he made a serious comment—with which anyone who has experienced a transformative personal psychotherapy can resonate—that analytic treatment is essentially a cure through love (McGuire, 1974, pp. 8–9).

When students are taught psychoanalytic therapy as a prototypical

technique from which unfortunate deviations are sometimes required, they quickly notice how inconsistently such an approach actually meets the needs of their clients. Beginning therapists rarely get the reasonably healthy, neurotic-level patients who respond well to strict classical technique. They can easily develop the sense that they are "not doing it right," that some imagined experienced therapist could have made the conventional approach work for this person. Sometimes they lose patients because they are afraid to be flexible. More often, fortunately, they address their clients' individual needs with adaptations that are empathic, intuitively sound, and effective. But then they suffer over whether they can safely reveal to a supervisor or classmate what they really did. When beginning therapists feel inhibited about talking openly about what they do, their maturation as therapists is needlessly delayed.

Despite the fact that we all need a general sense of what to do (and what not to do) in the role of therapist, and notwithstanding the time-honored principle that one needs to master a discipline thoroughly before deviating from it, the feeling that one is breaking time-honored, incontestable rules is the enemy of developing one's authentic individual style of working as a therapist. It is more important to know the knowledge base and the objectives of a discipline than to be able to mimic its most typical procedures. Techniques that are good general practices are not always appropriate in a specific context. Since at least the inception of the self psychology movement, there has been a substantial psychoanalytic literature on the importance of making one's interventions patient-specific rather than rule-driven. It is my impression that effective analysts of all schools of thought appreciate this emphasis, and that they did so long before reflections on technical flexibility dominated the literature on practice (for one example, see Menaker's 1942 paper on adapting psychoanalysis to the dynamics of masochistic patients).

The contemporary relational revolution may be viewed, at least in part, as a grass-roots effort to affirm the substance rather than the trappings of psychoanalysis. Many of the most articulate spokespersons for the relational movement have made comments, often privately and sometimes in print (e.g., Maroda, 1991), about their memories of struggling to progress in treatment in the face of their own analysts' rigidities. Now with the voice of a movement, they have effectively been protesting the ritualization of certain technical "rules" that grew to have a life of their own in the twentieth century, often in defiance of evidence that for many clients, the imposition of those rules was deadening rather than liberating.

PSYCHOANALYSIS AND THE PSYCHOANALYTIC THERAPIES

Psychoanalysis as it was practiced by Freud requires from the patient both a relatively secure attachment style and the capacity to be simultaneously immersed in and reflective about intense emotional experiences. It is therefore not the treatment of choice for most people whose task in therapy will mainly be to develop those capacities. Individuals with psychotic-level problems, active addictions, borderline personality organization, or significant antisocial tendencies are usually not good candidates for Freudian-style psychoanalysis. In addition, many people who could benefit from traditional analysis cannot afford the number of sessions per week that it requires.

Many writers make careful distinctions between psychoanalysis proper and the psychoanalytically based therapies that have been developed to treat individuals for whom analysis is either contraindicated or impractical. Some use the word "psychodynamic" for treatments that are less intensive than the procedure Freud invented yet depend on ideas that derived from his theories. In midcentury America, because of the unique cachet of psychoanalysis, many mental health professionals held the prejudice that even for patients with whom it is not feasible, the more closely one could approximate the technique of "real" psychoanalysis—the approach Freud (1919) had once described as "pure gold" as opposed to the "copper" of suggestion—the greater the value of the therapeutic experience for the patient. Hence, it became important to distinguish verbally the quality product from the knock-offs.

In accord with my inclination to emphasize continuities rather than discontinuities, I prefer to envision a continuum from psychoanalysis through the exploratory psychodynamic therapies in which transferences are invited to emerge and be examined in light of the client's history, then the transference-focused or expressive treatments that zero in on the here-and-now use of pathological defenses, and, finally, the supportive approaches for people who are in crisis or are struggling with severe psychopathology or are simply unable to afford treatments of more than a few sessions. At the ends of the continuum, the disparities are great enough to be legitimately considered differences of kind, but between four-times-a-week analysis and twice-a-week exploratory therapy, the difference seems to me to be one of degree (cf. Schlesinger, 2003). And although my experiences as both patient and analyst have led me to cherish traditional psychoanalysis, I regard the analytically influenced therapies not as a poor substitute for the real thing

but as valuable in their own right and frequently the treatment of choice (cf. Wallerstein, 1986).

Because I feel it is more important to understand general psychological principles and the phenomenology of individual differences than to master technical skills in the absence of those bodies of knowledge, I will not be describing in this book how to conduct *particular* therapies that have been derived from psychoanalytic ideas. These are better learned from adherents of the various delineated strategies for specific kinds of clients and situations. Moreover, especially as they accumulate clinical experience, most analytic practitioners work flexibly, shunning technical purity and basing their interventions on their intimate knowledge of each individual human being (or couple or group or family or organization) whom they try to serve. But for newcomers to psychoanalytic ideas I should say a few things about the concepts that are central to most psychoanalytic treatments, including classical analysis. I first note Freud's contributions to our theories of clinical process and then mention more contemporary ideas about both psychoanalysis and the psychoanalytic therapies. (For a less abbreviated history of psychoanalytic clinical theory than what follows, as well as an examination of empirical research bearing on it, see McWilliams and Weinberger, 2003.)

Freudian Psychoanalysis

Freud invited his patients to recline and relax and to speak as freely as possible, reporting every thought and feeling as it made its appearance in their consciousness. He tried to listen with a trance-like receptiveness ("evenly hovering attention") for the themes that emerged in their free associations, to interpret their meanings, and then to convey his understanding to the analysand (the analytic patient). He soon discovered that as people tried to do this, they struggled against inhibitions about saying everything on their minds and against impediments to acting on the basis of their newer insights ("resistance"). He also learned that they persistently responded to him as if he were more like a past love object than he viewed himself as being ("transference").

When he felt that a patient's attitudes toward him were evoking in him strong feelings that went beyond an ordinary professional desire to help, Freud called the phenomenon "countertransference." He emphasized the importance of the analyst's not taking personal advantage of the powerful feelings that analysands develop in treatment, especially when those feelings involve sexual desire and evoke a countertransferential excitement in the therapist, and he cautioned analysts not to use the power of their role in the service of indoctrinating or rescuing

their patients ("abstinence"). He also urged them not to intrude their own idiosyncratic personalities and agendas into the therapeutic setting and not to give in to "the temptation to play the part of prophet, saviour, and redeemer to the patient" (1923, p. 50*n*.). Instead, he exhorted them to try to act as mirrors of the patient's feelings and as blank screens onto which the person's internal images could be projected ("neutrality").

Resistance was initially regarded by Freud as a frustrating obstacle to be overcome. By that term he was not accusing his clients of being uncooperative; he was noting the power of unconscious efforts to cling to the familiar even when it had become self-defeating. Although in his early years of practice, he was known to complain to a patient, "You're resisting!," later he came to understand resistance as an inevitable process that must be respected and "worked through." Transference, too, was originally an unwelcome discovery to him, as it still is for many well-intentioned beginning therapists (even if one expects it, there is something disturbing about being the target of communications that seem to be aimed at someone else). Freud was troubled by the fact that while he was presenting himself as a sympathetic doctor, he was being experienced by his analysands as if he were a significant—and often problematic—figure from their past.

At first, Freud tried to talk his patients out of such perceptions by lecturing them about projection (attribution of one's disowned strivings to others) and displacement (deflecting a drive or affect from one object to a less disturbing one), but eventually he concluded that it is only in a relationship characterized by transference that significant healing can happen. "It is impossible to destroy anyone *in absentia* or *in effigie*" (1912a, p. 108), he pronounced, referring to how in analysis a person can bring about a different outcome to a problematic early struggle. What I understand him to have meant is that when the atmosphere of the patient's childhood emerges in treatment, with the analysand experiencing the analyst as having the emotional power of a parent, the patient becomes keenly aware of long-forgotten (repressed) feelings toward parental figures, can express what was inexpressible in childhood, and can, with the analyst's help, craft new solutions to old conflicts.

Freud saw his patients on successive days, five or six times a week. When therapist and patient are together this often, with one party urged to report uncensored thoughts and feelings while the other is relatively quiet, patients have more than passing transference reactions; they tend to develop what Freud called a "transference neurosis": a set of attitudes, affects, fantasies, and assumptions about the analyst that express central, organizing themes and conflicts dating from their ex-

periences as children. Later practitioners found that a transference neurosis would also emerge in treatments conducted at a frequency of three or four times a week. Psychoanalysis became defined as the process by which a transference neurosis is allowed to develop and is then systematically analyzed and "resolved" (Etchegoyen, 1991; Greenson, 1967).

Resolution meant piecing together an understanding of the diverse effects of one's core conflicts, ultimately substituting knowledge and agency for unconscious tensions that had been manifesting themselves as psychopathology. Freud understood his patients' symptoms to be expressing conflicts between unconscious wishes (e.g., for sexual or aggressive self-expression) and an equally unconscious intolerance of those wishes—intolerance that represents the internalization of societal messages, conveyed by caregivers, to the effect that certain desires are inherently unseemly or dangerous. Paralysis of the hand, for example, a disorder that is inexplicable neurologically yet was common in Freud's era,[4] was interpreted as a neurotic solution to the conflict between the wish to masturbate and the horror of masturbating, both of which were outside awareness. By helping via free association to make such tensions conscious, Freud tried to foster a sense of agency (in this instance about managing sexual needs), in place of the paralysis that was handling the problem outside of consciousness. In other words, he was trying to substitute a mindful, reality-oriented process for an automatic, unformulated, somewhat magical one that operated at the price of symptom formation.

Freud tended to use ordinary, straightforward terms for the phenomena he described (see Bettelheim, 1983). Some of the simplicity and grace of his language, and hence the ease with which psychoanalytic theory can be understood, was lost in the English-language edition of his works, possibly because his writings were translated by his reputedly quite obsessional former patient, James Strachey. The medicalization of psychoanalysis also tilted its language toward mechanization and objectification. It has been a loss, for example, to have Freud's "it," "I," and "I above" represented by the Latin terms "id," "ego," and "superego." Personal pronouns thus morphed into abstract agencies with little subjective resonance. As Jonathan Shedler once commented to me, it is easy for most of us to relate to the distinction between "I" and "it" in ordinary speech: "I did this" is a different experience from "It came over me." The conflictedness of human psychology, the insight that the mind is not unitary but multifaceted and divided against itself, is a profound yet simple idea.

Gradually, the term "psychotherapy" came to refer to modified arrangements in which a transference neurosis is not cultivated but in

which transference reactions are addressed, resistances are processed, and transforming insights are sought. The therapy client is not asked to lie down and say whatever comes to mind, but the therapist does invite the patient to speak as freely as possible about the problem areas that occasioned the treatment. While the two parties may try together to make sense of dreams and fantasies, as they would in analysis, they tend to keep focused on one or two central themes or conflicts. The therapeutic alliance is assumed to be internalized as a new model of relationship, as it is in analysis, even though the therapy partners do not search every nook and cranny of the client's psychic life. Recent research supports the value of psychoanalysis; in general, the more frequently and the longer one is seen in treatment, the better the outcome (Seligman, 1995; Freedman, Hoffenberg, Vorus, & Frosch, 1999; Sandell et al., 2000). Data from the comprehensive Menninger study (Wallerstein, 1986) suggest, however, that there are many individuals for whom psychoanalytic therapy is as effective as, or more effective than, psychoanalysis. This finding supports clinical observations to the effect that for some people, a less intense therapy is the treatment of choice.

Contemporary Conceptions of the Psychoanalytic Process

Clinical psychoanalysis, although invented as a therapy, has come to be defined as an open-ended effort to understand all of one's central unconscious thoughts, wishes, fears, conflicts, defenses, and identifications. People may seek analysis in order to pursue an agenda of personal growth or to develop a depth of understanding about universal issues with which their own patients struggle. Psychotherapy has more modest goals, such as relieving specific disorders, reducing suffering, and building stronger psychic structure. Analysis continues to be the most effective treatment known for resolving problems embedded tenaciously in one's personality, whereas therapy may adequately ameliorate more focal difficulties. Despite the convention of defining analysis as a treatment involving three or more sessions a week (usually on the couch), and psychodynamic therapy as twice a week or less (usually face to face), most psychoanalysts would probably agree that the critical difference between an "analysis" and a "therapy" is what happens in the therapeutic process, not the conditions by which the process is facilitated.

To accomplish the ambitious task of a full analysis, clinical experience suggests that patients must become comfortable enough to allow themselves, when in the therapy office, to "regress"—that is, to feel the

intense emotions characteristic of early childhood. Many patients report that as they begin to feel more child-like in the therapy hour, they simultaneously find themselves feeling more grown up and autonomous outside it; thus, they experience the regression as contained and coexistent with significant growth. In the context of that circumscribed regression, the analyst gradually attains, in the mind of the patient, an emotional gravity comparable to the power of early caregivers. The emotional power of the analyst when the patient is in a transference neurosis conduces to both healing and prevention. Therapeutic regression is more apt to happen under conditions of frequent contact between therapist and patient, but experienced treaters have noted that some people are able to undergo a deep analytic process in twice-a-week work, whereas others are not able to do so even after years of meeting five times a week.

The relational movement to which I referred at the end of the last section has brought a new language to the description of the psychoanalytic process. Relational analysts have drawn on diverse sources: the work of Freud's Hungarian colleague Sandor Ferenczi and his followers, Melanie Klein and the British object relations theorists, Harry Stack Sullivan and the American interpersonal movement, Heinrich Racker's writing on countertransference, Hans Loewald's conceptions of therapeutic action, Joseph Sandler's work on role responsiveness, Heinz Kohut's self psychology, Merton Gill's clinical theories, numerous philosophical writings on epistemology and hermeneutics, and many others. These influences converged in challenging the idea that the analyst is a neutral outsider who can comment objectively on the patient's internal dynamics (a number of psychoanalytic writers, starting with Schimek, 1975, have referred to this ideal as the doctrine of "immaculate perception").

Relational analysts have emphasized the interaction between the subjective experiences of both therapist and client and have pointed out that when they engage in a psychoanalytic process, *both* parties find themselves caught up in dynamics reminiscent of the client's early dramas. Countertransference is seen not as an occasional phenomenon but as a pervasive and unavoidable one; entry into the patient's subjective world tends to activate any compatible scripts from the therapist's life. Thus, a woman with a sexual abuse history and her therapist may find that they are subtly enacting familiar, reciprocal roles such as those that Davies and Frawley (1994) have noted as common in such dyads: "the uninvolved nonabusing parent and the neglected child; the sadistic abuser and the helpless, impotently enraged victim; the idealized rescuer and the entitled child who demands to be rescued; and the seducer and the seduced" (p. 167). "Enactment" (Jacobs, 1986) has con-

sequently become a central concept in psychoanalytic understanding of the therapy process. Disclosure to the client of the therapist's feelings and mental images, in the interest of understanding what is being recreated in the clinical setting, is not uncommon among contemporary psychodynamic practitioners.

Acknowledgments that enactments are inevitable, along with the associated conception of the therapist's role as expressing a privileged understanding of mutually constructed contexts and meanings, have become standard features of psychoanalytic discourse. Some analysts continue see value in regarding the therapist as a relatively objective outsider, as Freud did, and therefore put their emphasis on transference as distortion. Relational analysts regard objectivity as impossible and therefore see the transference–countertransference matrix as constructed jointly by the two parties. One welcome side effect of the evolving relational sensibility is that psychoanalytic clinical writing has gradually became less pronunciatory and more explicitly confessional, with therapists describing the nature of their own emotional involvement in the clinical process. Relational analysts tend to depict psychotherapy in more egalitarian and democratic ways than their "classical" predecessors. In a recent article in *The Psychoanalytic Review,* (Eisenstein & Rebillot, 2002), for example, a patient and analyst scrutinize their work together in hindsight, noting the emotional changes that each made during the treatment.

Given the long history of the psychoanalytic movement and the disparate directions in which psychoanalytic clinical theory has gone, I should address the question of diversity within the psychoanalytic community and locate myself in that context. Some readers may be familiar with the passionate ways in which analytic practitioners may embrace their particular psychoanalytic orientation. Does one self-define as classical or relational? Intersubjective or self psychological? Freudian or Jungian or Kleinian or Lacanian? The historical stew of psychodynamic theory and practice, from Freud on, is peppered with enough conflict, disagreement and schism to rival some medieval heresy controversies. It can seem as if there is hardly enough in common among practitioners of divergent leanings for all of us to fit under one psychoanalytic umbrella. In *Psychoanalytic Diagnosis* (McWilliams, 1994) I commented that while theorists spar in the service of promoting their favorite paradigms, ordinary practitioners tend to be more synthetic, taking concepts from different and sometimes even epistemologically contradictory sources when they seem to hold out a way of understanding and helping a particular patient. Pine (1990) likened the different viewpoints in psychoanalysis to the proverbial blind men and elephant: "The complexity of the human animal is sufficiently great such that we

gain in our understanding by having multiple perspectives upon it" (p. 4). The perspective represented in this book is synthetic in the spirit of Pine's observations.

MY OWN ORIENTATION

The reader is entitled to know something about my own identifications, affiliations, allegiances, and assumptions. In deference to compelling arguments made by numerous contemporary writers that one cannot be unbiased but can at least acknowledge biases that are conscious, I will try to describe and account for my own point of view.

Re: Psychoanalytic Pluralism

I first became interested in psychoanalytic theory as a government major at Oberlin College, while writing a senior thesis on the political theory of Freud. My own dynamics are sufficiently Freudian that I found his writing utterly compelling. Several books by his protégé, the psychologist Theodor Reik, were in bookstores at the time, and I began to devour them. After graduating, I moved with my husband to Brooklyn, where it dawned on me that Reik was still alive and in Manhattan. I became intrigued with the idea of meeting someone who had been so close to Freud and had written so movingly about the human condition. I wrote to him asking if he would meet with me and advise me about a career in psychotherapy. Reik received me graciously and urged me to go into analysis. Eventually I went into training at the institute he had founded, the National Psychological Association for Psychoanalysis (NPAP).

My graduate work in psychology was in the department of Personality and Social Psychology at Rutgers University. I had chosen to study personality rather than clinical psychology at Rutgers because Sylvan Tomkins, whose work I admired, was teaching courses in personality, and because my overall fascination with individual differences went beyond a strictly clinical interest. Once I had completed my master's degree, I enrolled in NPAP and took courses there at the same time I pursued the doctorate. While I was a graduate student at Rutgers, first George Atwood and then Robert Stolorow joined the personality faculty and began their extraordinarily fertile collaboration. I loved their work, though I sometimes felt puzzled by their tendency to see what they were doing as a challenge to traditional psychoanalytic ideas. Their ways of thinking felt quite congenial to me, and not in essential

conflict with what I had experienced in my own analysis or what I was learning in my analytic training.

At NPAP, what was generally considered "classical" was an orientation to treatment that came from Freud via Theodor Reik. It was on Reik's behalf that Freud had written his polemic to the effect that analysis should not become a servant of psychiatry. Having been excluded by the American medical institutes despite his mentor's position, Reik had started his own training program. His masterwork, *Listening with the Third Ear* (1948), which claimed direct descent from Freud's ideas, emphasized the artistic nature of the analyst's work, the value of letting oneself be surprised, and the virtue of moral courage, including the "courage not to understand." Most of my teachers and supervisors at NPAP in the 1970s embodied these attitudes. They taught me not just about Freud but about Ferenczi, Klein, Fairbairn, Balint, Mahler, Winnicott, Bowlby, Erikson, Sullivan, Searles, Kohut, and others. These thinkers were seen as carrying on Freud's work rather than replacing or contesting it. I was taught, as I will pass on in this book, that the criterion for whether an intervention has been proper or helpful is not the extent to which it follows a standard procedure but, rather, the extent to which it enables the patient to speak more freely, to disclose more genuine or troubling feelings, to deepen the work (cf. Kubie, 1952).

It was also frequently noted at NPAP, as it has been periodically in the psychoanalytic literature, that because psychopathologies differ from era to era and culture to culture, competing theoretical models arise from efforts to account for the psychologies of more typical therapy clients in any given time and place. Theorists derive their metaphors partly from working with a particular type of patient; thus, Freud, whose early work was with people with hysterical and dissociative psychologies, developed a model highlighting relations between different parts of the self experienced as in conflict, while Winnicott, who was fascinated by both infancy and psychosis (Rodman, 2003), created more holistic concepts such as "going on being." I rarely see anyone now whose psychology is best captured by the model of the id, ego, and superego in conflict, but in Freud's era, when stable patriarchal families and guilt-inducing child rearing were normative in Europe, such individuals were evidently abundant. I doubt that it is an accident that the self psychology movement arose in a time and place that creates as many problems for a consistent, positively valued self-concept as Western mass culture does. Similarly, the current popularity of relational paradigms makes sense in an age when authority is suspect and egalitarian models of relationship prevail (see Bromberg, 1992).

During my training in psychoanalysis I felt little pressure to declare

allegiance to a particular point of view, and, impressed with Freud's willingness to revise his ideas, I regarded this openness as quintessentially Freudian (which says a lot about my selective perception, given Freud's equally impressive tendency to ostracize people who disagreed with him). I read not only Freud's papers on technique but also some writing by people who had been in analysis with him, and I admired his individualized responsiveness to his various analysands (see Lipton, 1977; Lohser & Newton, 1996; Momigliano, 1987). On the basis of an identification with him as a curious, flexible therapist, I thought of myself as a Freudian.

It was not until several years after I had graduated from NPAP that I came into contact with a different version of the "classical" analyst, the one that emerged from the ego psychology movement as exemplified by Hartmann, Kris, and Loewenstein of the New York Psychoanalytic Institute. A colleague of mine who had trained at one of the "classical" analytic training centers often talked about "the rules" and seemed to suffer spasms of guilt when he broke them, even when the patient then flourished. He told me about a friend in his program who had said, "What I love about psychoanalysis is that you always know you're doing the right thing. Even if the patient gets worse or suicides, you know you've offered him the best." This idea that the operation could literally be considered a success even if the patient had died seemed bizarre to me, and originally I chalked it up to a peculiarly pathological narcissism in the psychologist in question. Over time, however, I heard one after another story of psychoanalytic rigidity and authoritarianism in the name of what was "classical." Eventually, I learned not to call myself either Freudian or classical, because I was typically misunderstood as an apologist for drive theory or a cheerleader for what then passed as orthodoxy in most institutes.

The truth is that I still think of myself as more Freudian than anything else, perhaps partly in appreciation of Freud's famous joke that he was not a Freudian. I have been deeply influenced by analysts who were self-identified as object relations theorists, Jungians, Kleinians, self psychologists, intersubjective theorists, control–mastery practitioners, and relational analysts. Arthur Robbins, who was running experiential countertransference-focused groups (see Robbins, 1988) and teaching about intersubjectivity long before that term appeared in the analytic literature, was my most influential mentor. I value and identify with contemporary relational analysts—not because I always agree with their arguments but because they have palpably advanced the level of honesty and the quality of dialogue in presentations of clinical work, increased the level of respect with which patients and their struggles

are described, and brought back to psychoanalysis the excitement of the search, the open dialogue, the spiritual quest.

Robert Holt once commented (Rothgeb, 1973) that if one approaches Freud's writing with an intent to debunk specific propositions, almost anything he said can be shown to be wrong, but if one approaches it with an interest in what can be learned, it will yield great insights. I have always felt that to get the most from any theory, psychoanalytic or otherwise, one is best served by extending to its proponents the respect one would grant a client. With patients, we try to understand where they are coming from, what problems they are trying to solve, what contexts make their solutions reasonable. When one is genuinely empathic, it is impossible to dismiss even a psychotic person as completely incomprehensible or hopelessly wrong-headed. Most theorists are struggling with their individual solutions to multifaceted human problems, and if we take their angle of vision, we can learn from them much of value. If, however, we substitute their conclusions for our own search for what is true, we will sell short our own capacities as meaning makers. Thus, I remain skeptical of orthodoxies, especially technical ones (cf. Pine, 1998), and agree with Roy Schafer (1983) that although there are advantages to working wholeheartedly within one's particular orientation, there are also advantages to questioning those assumptions, and to appreciating the inevitable heterogeneity within each school of thought.

Re: Psychoanalytic Therapy versus Other Approaches

I am often asked how I view nonpsychodynamic approaches to therapy. Notwithstanding my devotion to psychoanalysis, I have come to respect the evidence that there are numerous effective ways of helping people. Overall, if one subtracts the distorting influences of insurance and pharmaceutical companies, with their common interest in minimizing the value of psychological interventions, I think the challenges to psychoanalytic therapy from competing paradigms have been a positive development. A diversity of perspectives opens possibilities for finding specific approaches to specific difficulties (e.g., pharmacological management of bipolar symptoms, exposure treatments for obsessive–compulsive symptoms, twelve-step programs for addictions, and family systems therapy for dysfunctional relationships). Like most practicing therapists, I am grateful for any approach, whatever its theoretical origin, that increases my effectiveness or provides me with resources to offer to individuals who seek my help.

Currently, the most academically sanctioned ways of addressing psychological problems are the cognitive-behavioral treatments. The

intellectual forebears of cognitive-behavioral therapies are found in the empirical–positivist tradition of American academic psychology rather than in the European philosophical attitudes that influenced Freud. Although representatives of the psychodynamic and cognitive-behavioral traditions may work more similarly than would be obvious from their theoretical rationales (Wachtel, 1977, 1997), their overall notions about the nature of suffering, the nature of change or help or "cure," and even the nature of "reality" diverge significantly. Some patients seem to prefer more focused and directed treatment, complete with homework assignments and systematically targeted symptoms, and some seem to be allergic to them. Many of the cognitive and behavioral therapies have demonstrated their effectiveness, at least in the short term and with the populations on whom they have been tested.

I do not think, however, that alternative approaches dramatically shorten the amount of time needed to help people with longstanding and far-reaching problems—that is, most people who seek therapy. It is worth noting that all mainstream approaches to psychotherapy, including psychoanalysis, have begun their respective journeys by claiming impressive accomplishments in a stunningly short period of time, and then all have lengthened as their practitioners have faced the complexities of the work. For Freud, a "psychoanalysis" could be as brief as a few weeks, but as he and subsequent analysts encountered the phenomena of resistance and transference and the intricacies of individuals' dynamics, analytic treatments began to extend over several years.

In the 1980s, therapists in the dissociative disorders field repeated Freud's journey toward progressively longer and more complicated treatments for individuals with posttraumatic symptoms: They initially described therapy for dissociative clients in terms of remembering and abreacting, as Freud once did, and they only gradually addressed the complexity of memory, the stubbornness of emotional habit, the importance of attending to the therapeutic relationship, the multiple functions of symptoms, and the consequent need for long-term treatment for complex trauma. Carl Rogers originally claimed that client-centered therapy could foster significant change in a few sessions, and yet humanistic therapists now work with their clients for years. As cognitive-behavioral practitioners wrestle with ongoing problems of relapse-prevention and expand their work into the treatment of personality disorders, the cognitive and behavioral therapies are also becoming prolonged. Eye movement desensitization and reprocessing (EMDR), once heralded as a quick fix for trauma, has expanded into a complex psychotherapy system of its own. We all keep learning the same lessons.

Different sensibilities appeal to different people, and different means of approaching problems operate within a larger arena of helping relationship common to all psychotherapies (Frank & Frank, 1991). Clinicians practice in ways that make sense to them and that express their individuality. I would be reluctant to train anyone in psychodynamic therapy who is not temperamentally attracted to the *gestalt* I describe in the next chapter, just as I would be reluctant to give musical instruction to someone with a tin ear. (This comparison may be more than a felicitous simile; both musical aptitude and affective attunement seem to be distinctively right-brain phenomena, embodying individual differences in both genetics and infantile experience [Schore, 2003a, 2003b].) Correspondingly, as someone with a psychoanalytic sensibility, I would be hopelessly maladroit at practicing within a manualized cognitive-behavioral framework. (Too left-brained for me, I suppose.) Our talents and inclinations as practitioners are varied enough to encompass many different kinds of work. From my perspective as someone who cringes when authoritarian procedures are purveyed as the essence of psychoanalytic therapy, an accidental benefit of the fact that analysis is no longer intellectually dominant in medicine, clinical psychology, and social work is that only those students with genuine psychoanalytic affinities will now be likely to seek analytic supervision and training. I am hoping this change portends fewer instances of unimaginative, unempathic, dogmatic, routinized psychodynamic therapy in the coming years.

Even though medical metaphors pervade the clinical literature, the practice of psychotherapy is an art, and as such can be compared more aptly to disciplines of musical expression than to medical treatments. There is a science and a theory behind music, but when translated into performance, music offers its afficionados a particular mind–body–feeling–action experience. Music seems be registered by the brain in characteristic ways, irrespective of the particular musical preferences of the listener. Correspondingly, the question of which approach to therapy is globally superior seems to me as misdirected as the question of whether classical, jazz, rock, folk, or country music does a better job of nourishing the soul.

If I had not already come to this conclusion on observational and experiential grounds, I would have been drawn to it by Bruce Wampold's (2001) brilliant analysis of relevant empirical research. What Wampold calls the "contextual" or common-factors model of psychotherapy accounts far better for what we know about treatment outcome than the medical model that has influenced so much recent research and social policy. What are the implications for patients looking to

make sense of all the competing voices in the mental health field? As Messer and Wampold (2002, p. 24) have concluded, "Because more variance is due to therapists than to the nature of treatment, clients should seek the most competent therapist possible (. . . often well known within a local community of practitioners) whose theoretical orientation is compatible with their own outlook." In the next chapter, I look at habits of mind that characterize those of us whose outlook is psychoanalytic.

NOTES

1. The late Herbert Strean told me (personal communication, March 17, 1976) that once, in a radio interview, he was challenged about whether psychoanalysis is not just "another religion." "Oh no!" Strean protested, "Psychoanalysis differs from all *other* religions. . . . " I have since heard a similar anecdote attributed to Ralph Greenson. The pleasure with which analysts describe this Freudian slip may say a lot about its truth.
2. Douglas Kirsner (personal communication, July 5, 2002) tells me that a critical component of this stance was the fear, documentable from 1938 on, that the immigrating European analysts, many of whom lacked medical training but had the luster of having worked with Freud, would successfully compete with American psychiatrists for patients.
3. I am grateful to Paul Mosher for calling to my attention this practical consequence of the medicalization of psychoanalysis.
4. When I recently taught in Istanbul, I learned that in Turkey, "Freudian" afflictions such as anesthesia of the hand ("glove paralysis") are still common. Daughters of traditional or fundamentalist Muslim parents who convey disapproval or fear of female sexuality seem to suffer the same problems that once plagued young women in sexually strict Viennese families.

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