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BRIEF BACK COVER BLURB

Psychoanalysis has evolved over the last several decades; the stereotypic image of the unresponsive, disengaged analyst has given way to a reality where analysts find themselves clinically capitalizing on instances when they become swept up in the treatment more than they'd planned. Some analysts see such enactments as the new "royal road to the unconscious" while others beg to differ—seeing these clinical events as insurmountable yet regrettable instances of the analyst's failure to live up to his duty to contain the patient's material rather than enact it.

The enactment debate is but one of a slew of controversies swirling about psychoanalysis of late. Another debate centers on whether analysts can truly be objective, leading analysts who think not to deem the practice of interpreting to patients bogus at best, if not potentially harmful for patients whose pathology readies them to be misled. Other controversies raise questions about whether efforts to reach a widening scope of patients might water down psychoanalysis, causing it to lose its essence A particularly galling controversy involves the question of whether any given treatment approach trumps others in terms of effectiveness, as some analysts contend. And then there's the controversy within the general populace that questions the legitimacy of psychoanalysis itself—whether it can be scientifically validated or, rather, is a gigantic hoax.

This book outlines some of the chief controversies, introducing some additional controversies along the way, such as the one that has to do with how a given analyst's theory serves to determine what he considers salient, causing him to implicitly search for certain sorts of data while overlooking other types of data. This book covers the waterfront by addressing controversies that help further the field by raising questions that help evolve the treatment, challenging every analysts to re-think what he's doing in the consulting room . . . and why.

The Psychoanalytic Method in Motion identifies and examines varied controversies about how psychoanalysts believe treatment should best be conducted. Irrespective of their particular school of thought, every analyst builds up a repertoire of his favored ways of working, which he believes to be the most efficacious approach to treatment. While such differences of opinion are unsettling and may even cast doubt on the field's legitimate status as a scientific endeavor, this book sees these differences as leading to major changes in how psychoanalysts and psychoanalytic psychotherapists practice.

In this book, Richard Tuch covers the waterfront by examining controversies that further the field by raising questions that help evolve the treatment, challenging every analyst to re-think what they are doing in the consulting room…and why. Some of the chief controversies explored include:

- the enactment debate—unparalleled tool or regrettable error?
- whether analysts can truly be "objective"
- the advantages and dangers associated with the analyst's use of authority
- the ways in which theory influences the analyst's implicit search for data, blinding him to evidence he dismisses as irrelevant
- whether any given treatment approach trumps others in terms of effectiveness, as some analysts claim
- the legitimacy of psychoanalysis itself—whether it can truly be considered scientific
- whether certain methods of supervision are more effective than others
- whether free association can be considered therapeutic beyond its data-revealing capacity
- the extent to which an analyst preferred clinical theory is a product of his personality

Drawing on ideas from a range of different analytic perspectives, this book is an essential and accessibly written guide to working towards best practice in the analytic setting. *The Psychoanalytic Method in Motion* will appeal greatly to both students and practitioners of psychoanalysis and psychoanalytic psychotherapy.

This book is dedicated to Jim Grotstein
Who lapped up life
Like a dog does his water
Who lived his life
Like there was no tomorrow
Who loved us all
Like mama does her baby
And left us all
Much wiser though heart achy

ENDORSEMENTS

Rethinking fundamental assumptions in the light of his clinical experience, Richard Tuch offers readers a thoughtful and intelligent appraisal of some of the most urgent issues in contemporary psychoanalytic practice. His writing avoids authoritarian pronouncements and partisan advocacy and focuses instead upon the generative tensions and productive changes that can arise from exploring conflicts and divergent views that exist among the various theories that populate the current analytic landscape. The result is a thought-provoking encounter with many of the vital challenges and controversies that preoccupy our field.

Howard B. Levine, MD

Tuch, a distinguished psychoanalyst, talented writer and gifted teacher, approaches psychoanalysis in the way that a good psychoanalyst approaches a patient, respectful of pre-existing ideas but encouraging an open-minded acceptance to alternative perspectives. Tuch's view is that theories should operate at the back of the therapist's mind, never distracting from the immediate clinical experience, but helping to define what that experience is. He recognizes the importance of the analyst's personality and style as well as his theoretical orientation. For Tuch there are many possible perspectives on the analytic encounter, just as there are many possible perspectives on life experience. In this comprehensive book, he offers an analyst's understanding of analysis, paralleling the analyst's understanding of human experience.

Robert Michels, M.D.

In this landmark contribution, Richard Tuch surveys the broad landscape of psychoanalytic technique He considers what the analyst does and why does it He discusses all of the important controversies that have developed over the decades since Freud. His range is wide and his analysis is deep. It deserves a place in the library of every psychoanalyst.

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Arnold Richards, M.D.

Introduction

Psychoanalysis is an exciting and dynamic field of study as well as a compelling method of treatment, and it has been my privilege, over the last 20 years, to have been able to participate in a dialogue – through the publication of papers and the delivery of talks – about the controversies that rage whenever experienced, well-trained psychoanalysts gather together in the same room and futilely try to reach agreement about how psychoanalysis should be practiced. The degree of disagreement may be seen by some as a sign of weakness in the field and may set in motion a search for "common ground" (Wallerstein, 1988) that establishes that analysts are more alike in how they actually practice than controversy would lead one to believe.

When the debate about technique becomes rancorous – as it often does – some analysts may dispute whether the technique used by certain other analysts deserves to be called by the same name as what they themselves do in their own practices. The charge that often gets leveled – "what you do isn't analysis" – is highly presumptuous and runs counter to how most analysts appear to feel about unwarranted certainty and the recognized value of maintaining an "unknowing stance" when considering clinical material that requires open-mindedness rather than dogmatic insistence about what one imagines to be true. Assuming the right to speak authoritatively on what constitutes superior treatment may develop as a result of various factors: a) from an old-fashioned, know-it-all brand of narcissism that is accompanied by unwavering certainty that one's perspective trumps all others; b) from one's affiliation with a given school of thought – leading one to argue vocally about the superiority of that school's theories or approach to treatment or, alternately, to come to the aid of a like-minded colleague who'd been injured by the harsh criticism of an analyst who hails from a different camp against who one retaliates by taking issue with his thinking; or c) from becoming convinced by one's clinical experiences that a given perspective stands the best chance of shedding the most light on the largest segment of a patient's psychopathology and, furthermore, that this perspective provides the greatest amount of guidance about how best to approach the case from a clinical perspective. Whatever the cause, a lack of civility when dealing

with colleagues and an expression of mean-spiritedness, which is never called for, should be identified for what it is and challenged at every turn. Freud's (1930) concept of the "narcissism of minor differences" helps account for such developments – the idea being that slight differences between groups of people who are otherwise very much alike are taken to represent critiques of one's way of being or beliefs, the reaction to which binds the group in angry and aggressive opposition to the other group.

Given such conditions, offering one's views about the psychoanalytic method risks placing one in the thick of it, with enough analysts lying in wait to pick apart whichever expressed positions fail to conform to their own ways of thinking. Don't get me wrong – I am not speaking about the way in which most analysts act, but rather how a small handful of vocal critics have been known to act as they assert and/or defend their own brand of psychoanalysis with a passion. Such is the environment into which I walk as I offer a book exclusively focused on the matter of technique.

Contentiousness can lay bare an existing schism that can easily cast doubt on the legitimacy of the field. If psychoanalysis is scientific, as some claim it to be, then analysts might be expected to reach a semblance of consensus. But as potentially divisive and undermining as controversy can be, it propels change by challenging analysts to collectively examine, question, and rethink certain of their most essential assumptions to see whether they still hold water or, rather, should be discarded to make room for theories and perspectives that are more consistent with evolving knowledge coming not just from the consulting room, but from other fields of study as well: from infant observation, neuroscience, social psychology, academic psychology, and the like. Many of Freud's original hypotheses have fallen by the wayside – dismissed by Freud himself as no longer adequate to account for phenomena he came to see as being more complex than he had at first imagined. After all, do we still believe that syphilitic fathers beget hysterics? Aren't we past believing that conflicts around issues of control are strictly born of anal phase pathology? A more recent example includes the effect infant observation has had on our former belief about infantile symbiosis, which has been all but banned as a legitimate developmental construct.

Not everyone appreciates just how dynamic the field of psychoanalysis can be. Its critics would have you believe that analysts practice in precisely the same way as Freud did over a century ago – that psychoanalysis is an arcane method of treatment practiced by a dwindling group of aging doctors who are stuck in their ways, deaf to the changing world about them that has essentially left them behind. Better they get their noses out of books and wake up to that changes taking place in the outside world – a world that hasn't the patience for analysis, given the pace of life and clamor for instantaneous relief and immediate gratification. Against the backdrop of this portrayal is reality – close examination leaves little doubt that psychoanalytic technique is indeed evolving.

While the psychoanalytic method that Freud discovered is remarkable in its original iteration, it must continue to evolve to stay relevant. Though psychoanalysis has been dismissed by many – particularly in the United States – as antiquated and passé, such conclusions aren't warranted given how far the field has come – the result of dedicated analysts doing their best to work out the kinks and find alternate ways to conceptualize how and why patient's fall ill and what methodologic changes might make the psychoanalytic approach to treatment more effective. Therapeutic failures are studied with an eye toward discovering what went wrong – was it the theory? The technique? A poor match between patient and therapist? Maybe the countertransference? Maybe the patient's pathology lies beyond the field's ability to treat? Psychoanalysts give due consideration to such matters, grappling with how to improve our methods. Psychoanalytic technique has changed, and continues to change, as psychoanalysts study not just what went wrong, but why certain treatments work as well as they do. Yes – people are getting treated and people are getting better, people for whom psychoanalysis appears to have been the most efficacious treatment available, as scientific studies have now shown it to be. But we've gotten ahead of ourselves insofar as the topic of the scientific basis of psychoanalysis doesn't appear until the tail end of the book.

This book is about the controversies that have swirled around the topic of technique for the last several decades. It is also about the evolution of the psychoanalytic method – how psychoanalysis, as it is practiced today, differs markedly from how it had been practiced in days gone by. The process by which the development of psychoanalytic technique evolves over time often involves a swing from one accepted position to its opposite (from thesis to antithesis). This sometimes involves an overstatement of the flaws of the original position (throwing the baby out with the bathwater based on a straw-man argument that over-simplifies standard operating procedure) and a celebration of the benefits of the new position that, for a time, fills many with hope that an answer has finally been found that solves the shortcoming of the "old" method. Finally, clarity reigns with the development of a new tool that many hope will prove infinitely better. Detractors grunt dismissively about "old wine in new bottles," while the most fervent followers of the new method declare that "we've arrived," forgetting that "arrived" implies a final destination, which this new method can't possibly be. Its limitations and flaws will be discovered sooner or later, but for a time, the celebration continues.

The way in which psychoanalysis has evolved can be thought to exist on a macro and a micro level, which is best illustrated by a line graph that appears at first glance to be on an unrelenting uphill course when viewed from a distance. This belies the ups and downs that are noticeable upon closer inspection. Such micro-trends represent a pendulum swing that moves in an extreme direction before the situation rights itself through a process of moderation. This is one of the two main points made in Chapter 3, in which I argue that the "enactment movement" – if we dare call it that – has gone too far, to the

extent some act as if countertransference enactments are the gold standard – the new "royal road to the unconscious" – leading some analysts to conclude that any analyses devoid of stark enactments are poorer as a consequence in comparison to analyses in which powerful enactments are seen as propelling analytically facilitated change in a way nothing else can. Controversy developed when Steiner (2006) issued a sobering reminder that enactments, while inevitable and unavoidable, represent a breach in the analyst's duty to contain the patient's material, rather than become swept up in the material (even *swept away* by it), raising concern about whether the analyst will, first, catch on in a timely fashion to the fact he's lapsed into enacting, and then, will he find ways to successfully make effective clinical use of his realization of what the enactment means. Steiner's warning runs counter to Boesky's (1990) bold assertion that "If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis *will not proceed* to a successful conclusion" (p. 573, italics added). Furthermore, it seemingly ignores the clinical problems that could develop if an analyst fails to be "role responsive" to a patient's attempts to assign him a given role consistent with the patient's transference (Sandler 1976), or – put in other terms – when the analyst fails to accept and resists the urge to interpretively counter something the patient has attributed to the analyst that the patient needs for the two of them to "live with" the patient's construction of reality for the time being (failure to "*wear the attribution*," Lichtenberg, Lachmann, & Fosshage, 1992, 1996 – touched on in Chapters 3, 7, and 9). I liken such situations (failure to be role responsive or to wear the attribution) to a "block at the net" (when, in volleyball, the ball is kept from making its way across the net to the opposing side's court), which can represent the analyst's refusal or unwillingness to "play ball" for the sake of the treatment. A dialectic develops between the position taken by Steiner and those taken by these other authors – a dialectic that moderates the concerns raised by each party – thus illustrating one of the many controversies raised in this book.

When looked at from a macro level, the enactment movement seemed headed in a direction diametrically opposed to the one commonly held a half century ago, when countertransference was seen as a sign that the analyst needed a bit more analysis himself to "work out" his countertransference inclinations that ran the risk of contaminating the analyses he was conducting. Nowadays, certain analysts are of the opinion that analysts who are characterologically disinclined to lapse into acting out their countertransference feelings are essentially robbing their patients of a clinical experience that might prove to be amongst the most powerful and mutative of all the tools analysts now have to offer.[1] Note how the hero–villain structure of discourse is retained in spite of the swing; all that's changed is which of the two types of analyst – enacter vs. container – is thought to be providing their patients with the most optimal therapeutic environment. Today, analysis of the analyst's countertransference reaction (his total emotion reaction to the patient,

not his idiosyncratic reaction to the patient that is relatively independent of the particulars of the patient) has taken center stage in many analyses, to the extent such data is not theoretic and, accordingly, less likely to generate interventions or interpretations that are more intellectual and speculative in nature. Furthermore, there is a heightened emphasis on the part of certain analysts to consider his own personal contribution to the countertransference, which reminds him to remain aware of who is who. "I think it is fair to say," notes Kernberg (1993), "that all analysts utilise the exploration of their own affective responses to their patients in a consistent and much freer way than earlier clinicians did." (p. 662). Kernberg also advances the idea that "projective identification" has also become widely accepted as a legitimate and useful clinical phenomenon.

Sometimes, evolving theory takes our field too far afield before eventuating in a synthesis between extremes that is not nearly as hyperbolic. Renik (1993) provides a particularly good example of an analyst who's inclined to bolster his arguments using such absolute words as "always" and "never" – doing so eleven different times in this one paper alone (e.g., "awareness of countertransference is *always* retrospective, preceded by countertransference enactment" which he declares to be "*invariably* the case," p. 556). While some readers might feel reassured by statements that are made in no uncertain terms, the absoluteness of such statements should give us pause. Renik not only made absolute statements about his contention that analysts only know their countertransference reactions after the fact; he also argued that analysts cannot be said to possess anything approximating objectivity. Renik may not have recognized at the time that he was going too far out on a limb when he wrote "the fact that we still use the term *interpretation* would seem to indicate the extent to which we retain a conception of analytic technique as potentially objective, rather than inherently subjective" (p. 559), which led Renik to call upon analysts to cease referring to their interventions as "interpretations." To his credit, five years later, Renik (1998) came to the realization that he'd gotten dangerously close to disclaiming the scientific basis of psychoanalysis, which caused him to backpedal, restoring the analyst's right to claim to be objective by employing a most interesting and contorted argument that helped him retain, in part, his original position: analytic objectivity is possible, noted Renik, if – by that term – one means the analyst's acceptance of the fact that his subjectivity is an insurmountable factor in interpretation. The ongoing debate about the analyst's use of authority (see Chapter 4) and the legitimacy of his claim to have something authoritative to say about the patient's psyche rages on.

One can identify certain macro trends in the way in which analysts of varying stripes and colors conduct psychoanalysis today in comparison to how it was practiced decades ago (see Kernberg 1993). One of the most noteworthy changes is a de-emphasis on attempts to genetically reconstruct the patient's past (recover lost memories), in line with doubt that's developed about the

analyst's capacity to do just that. Reconstructions of the sort Freud offered the Wolf Man about his dream ("*He had been sleeping in his cot, then, in his parents' bedroom, and woke up, perhaps because of his rising fever, in the afternoon, possibly at five o'clock, the hour which was later marked out by depression... When he woke up, he witnessed a coitus a tergo [from behind], three times repeated; he was able to see his mother's genitals as well as his father's organ; and he understood the process as well as its significance*," Freud, 1918, p. 37) seem highly doubtful if not downright absurd in retrospect, and have given way to the construction of narratives more reflective of a central focus on the here-and-now transference, which can involve an emphasis on narrative truth over historical truth (Spence, 1982; Schafer, 1976, 1992), thought to capture a given patient's "story" about who he is, why he acts as he does, why he's developed the symptoms he has, etc. No longer are analysts willing to settle for a patient's "buying" the analyst's reconstruction on the basis of "an *assured conviction* of the truth of the construction" (Freud, 1937, p. 266, italics added) in the absence of the patient's failure to be able to recollect such a hypothesized occurrence. This isn't to say that reconstruction has entirely been set aside; it is only to note that reconstruction takes a back seat to an examination of the here-and-now unconscious aspects of the transference.

The depth at which analysts attempt to work with a patient's material has also changed. Whereas Kleinians of yesteryear had been inclined to focus on the deepest level of anxiety (Segal, 1973), Kernberg (1993) notes that Hanna Segal "now stresses interpretation at the most active – not deepest – level of anxiety, and with the patient's current level of mental functioning" (pp. 661–662), which is very much in line with the long-standing tendency of modern ego psychologists (Busch, 1995; Gray, 1994) to work from surface to depth, calling the patient's attention to evidence of defenses in action before setting out to determine what those defenses aim to defend against, in line with Fenichel (1945). There has been a comparable shift away from the analysis of specific symptoms or parapraxes to a more holistic analysis of the patient's character and character resistances as manifest in repetitive behavior patterns. Kernberg (1993) also notes an increased tendency, even on the part of ego psychologists, to think in terms of object relations, though he notes a distinction between how analysts who remain chiefly wedded to classic drive theory conceptualize object relations relative to those who are more inclined to focus on the patient's affects separate and apart from how those affects may arise due to wishes to gratify, or in reaction to a frustration of, the patient's drives. We have also seen a diminution in the central role of dream analysis – which isn't to suggest that it hasn't any place; rather, it is to emphasize "the multiplicity of 'royal roads' to the unconscious" (Kernberg, 1993, p. 663) – verbal content, nonverbal content, and the qualities of the relationship that develops between analyst and analysand. Concern has also been widely expressed about the analyst's reliance on his authority – something analysts were more inclined to do in the past, which analysts these

days worry may indoctrinate the patient into the analyst's ways of thinking (his theory). Such concerns have led some analysts to take such care to avoid imposing their ideas on the patient that they have all but abdicated their responsibility to provide patients with an alternate point of view on the patient's situation (yet another example of a pendulum shift), a topic discussed in depth in Chapter 4.

Psychoanalytic technique in focus

Freud's legacy is rich, but of all his gifts, the one I personally am most thankful to have received is his development of a method of treatment – an approach that has benefited mankind more than many realize. The particular component of psychoanalytic technique that comes closest to constituting "common ground" is that of free association, which remains in effect worldwide in the form of a widespread, unshakable belief on the part of analysts in the clinical value of the fundamental rule, and a corresponding reliance upon free association, which steers every analysis. The first section of the book – "The duties of analyst and analysand" – contains four chapters that outline some of the current controversies involving the clinical method. In Chapter 1, we examine patients' difficulties free associating from two vantage points: one having to do with a patient's difficulty switching between alternate modes of cognition – between "making happen" and "letting happen," between "doing" and "being" – and the other having to do with the patient's difficulty recognizing that he has a mind of his own that's become lost in the shuffle because the patient's "as if" tendencies (Deutsch, 1942), which have him adapting to the object world in a chameleon-like fashion, effectively hiding his true self *even from himself*. While free association provides a glimpse into the patient's unconscious, revealed in his difficulties in daring to "let go" (let happen), there is reason to believe that free association, in and of itself, may prove therapeutic to the extent patients who seek treatment are often plagued not only by symptoms, but also by impairments in their ability to freely navigate the inner passages of their mind without experiencing persistent pressure and dread that keeps them from wandering into psychic spaces where frightening skeleton's may be hanging or painful memories may be lurking. Slowly gaining the ability to think in a more free-ranging fashion is typically thought to solely develop as a function of interpretation that helps reveal resistances/defenses, which then get worked through to such a degree that the patient becomes better able to move about in his mind without dreading what he might encounter. How one comes to be able to more freely associate may prove to be a bit more complicated than was just outlined. While making the unconscious conscious remains a vital, essential, and laudable goal, it may not be the sole way in which psychic flexibility develops. Exercising the mind and developing a heightened capacity to, for example, shift more nimbly between passive and active modes of cognition might be

an added way in which one improves overall psychic functioning. The same might be said of patients for whom free association may be a way to find their lost selves buried beneath the rubble of their attempts to protect the self from being exposed to the danger of being discovered, invaded, and negated. These two alternate modes by which a patient may gain a heightened capacity to free associate – making the unconscious conscious and exercising the use of one's mind by surrendering to the task of free associating – needn't be considered an either-or proposition, and both mechanisms may contribute their share to what is achieved clinically.

Chapter 2 addresses how theory determines what the analyst deems as salient and how an analyst's particular analytic theory directs his search for "evidence" – thus demonstrating the extent to which theory functions by implicitly[2] alerting one to be on the lookout for certain sorts of evidence, which necessarily blinds one from noting other types of clinical data. As much as analysts pride themselves on being remarkably open-minded and unflinchingly observant, there is sufficient reason to doubt such claims. Theories function like polarizing filters that "let in" only a certain select segment of the data – that which is noted because it's deemed salient (relevant) in accordance with one's particular theory. Without the aid of theory, psychoanalysts wouldn't have a clue about the sorts of clinical data that should be prioritized as they search for evidence that goes on to become the data upon which to base their understanding of the patient. For example, an analyst who subscribes to modern ego psychology will be apt to "closely monitor" the patient's associations with an eye toward noting shifts in the patient's associations (Busch, 1995; Gray, 1994) – shifts that alert the analyst to the fact that a defense is afoot. This results in selective attention that keeps the analyst from noticing *other types of data*, given the fact that minds have a limited amount of "RAM" with which to work. A noted failure on the patient's part to stay with a given train of thought wherever it may lead is, for the ego psychologist, a "selected fact" – evidence of a defense in action – which the analyst will then use to help determine what the patient might be defending against in accordance with the goal of defense analysis. A selected fact, which may be born of one's theory and, in turn, may be used to support one's theory about a given patient, differs from an "overvalued idea" (Britton & Steiner, 1994) that runs the risk of leading the analytic couple astray when the analyst and/or the analysand come to accept the selected fact as if it represented the long-awaited answer that now satisfactorily solves the patient's problem. This chapter also examines the belief that the analyst's clinical activity (e.g., his interventions) are the result of conscious, careful deliberation that weighs the pros and cons of the options under consideration. While many interventions may in fact be the result of such conscious, willful deliberation, more and more analysts are willing to admit to instances when something just "blurted out" of their mouth unthinkingly or to instances when they'd found themselves

acting in ways without being quite sure what had gotten into them. A particularly illustrative example of this is provided by Jody Davies (1999), who describes her actions during a given session with a patient named Daniel:

> The next thing I knew, I was standing next to Daniel's chair wrapping a blanket around his shoulders, *not quite sure how I ended up there.* I remembered reaching with a disembodied arm into the cabinet where I kept the blanket for my own occasional use, and then getting up out of my chair, *but these were not considered actions.* (p. 193, italics added)

Davies' description will surely spook certain analysts who find it impossible to imagine acting in such a way, but that doesn't mean they don't engage in more subtle forms of the same type of unwitting activity. Finally, in this chapter, we consider the question of whether insight itself is what is mutative or, rather, whether it is the *process by which insight comes about* – whether it's the journey more than the final destination that is of greatest value.

We have already touched on one of the two chief themes of Chapter 3 – the matter of how the evolution of psychoanalytic theory sometimes takes place in extreme pendulum swings. While I agree with the movement that finds great value in the analysis of countertransference enactments, I take issue with those who believe in the hierarchical importance of enactments as if they now constitute – and should constitute – *the* essential component of treatment – another hyperbolic swing of the pendulum in a direction I believe will eventually prove undefendable and unsustainable. The other issue addressed in this chapter has to do with the relationship between the analyst's personality and how it influences the way in which he goes about practicing analysis. Journal reviewers who commented on this paper during the submission process were concerned with the idea espoused in an earlier version of the paper (since removed given their objection, though hints of it remain) that the theory a given psychoanalyst ends up adopting oftentimes proves to be a function of that analyst's personality. Such thinking is in line with what Stolorow and Atwood (1979) proposed in *Faces in a Cloud*, in which they correlated the particular theories promoted by some of our earliest psychoanalytic pioneers (Freud, Jung, Reich, and Rank) with their personalities, convincingly establishing the role personality plays in theory development. These reviewers were concerned that such a claim on my part could be seen as calling into question the scientific basis of our field. I don't see why that would be so, and I remain a firm believer in the science of psychoanalysis, though I do feel that the theory one relies upon is a personal, though unconscious, choice that goes on to help determine what the analyst finds salient in the patient's material (Chapter 2). At the same time, I believe that whatever is chosen as salient becomes grist for the mill – that analysts should not believe they are aiming to discover *the* essential truth of a patient's life when, in fact, there are a host of varied essential truths from which to pick, all of which I believe could prove

fruitful when explored. We should not have to worry that one psychoanalytic theory leads to the truth, tossing all other theories into the hopper labeled "also ran."

Chapter 4 addresses a controversy about the pros and cons of the analyst's use of authority when he takes a stand about what he thinks he sees reflected in the patient's behavior, which he fashions into an interpretation that's offered for the patient's consideration. Some analysts believe interpretations, backed with the power of the analyst's authority, run the risk of creating the impression that the analyst is denying or negating the patient's perspective about the matter at hand, leaving the patient feeling wiped out in the process, as if he'd been told that he doesn't know the first thing about his own psyche. It probably goes without saying – but had nevertheless best be said – that this is the last thing any analyst wishes to convey to a patient as a result of offering an interpretation meant to be helpful rather than hurtful. But, assuredly, there are instances when patients nevertheless feel diminished, dismissed, assaulted, and so on when the analyst offers an alternate perspective to the one held by the patient about the patient's situation or condition. Such dangers aren't always avoidable, though they may prove surmountable to the extent a vigilant analyst quickly notes that the offered interpretation has made matters worse, resists the urge to see the matter as one of a negative therapeutic reaction, and sets himself to the task of exploring with the patient what it was about the analyst's interpretation – or, maybe more to the point, the experience of being interpreted – that had so effected the analysand. Certain analysts are adamant that the attendant dangers of interpreting are so great as to make the act of interpreting counter-therapeutic either for certain sorts of patients or for all patients (a subject illustrated in Chapters 5 and 6). This chapter examines the debate about whether analysts can consider their interpretations "objective," given the influence of the analyst's "irreducible subjectivity" (Renik, 1993), which some believe to be so contaminating as to challenge the analyst's claim to have anything approximating expert knowledge about the patient's mind. In yet another pendulum swing, some analysts have taken to privileging the *patient's* perspective over the *analyst's* perspective, which, as I argue, gets analysts into a pickle if analysts wish to retain the claim of having something worthwhile to offer patients.

The widening scope of psychoanalysis – how treatment might be modified to accommodate patients who are too scared to think (Chapter 5) or who exhibit thinking that is primarily concrete (Chapter 6) – is addressed in Section II of this book – "Treating certain sorts of patients." Chapter 5 describes the sorts of difficulties encountered, and the technical modifications required, when treating patients whose separation anxiety makes it exceedingly hard for them to be able, in particular, to tolerate evidence of differences between themselves and others. The intensity of this anxiety makes it nearly impossible for such patients to permit their analysts to do anything that might draw attention to the ways in which the two differ because the evident gap is

not one the patient can easily live with, which causes him to react violently – for example – when the analyst is caught thinking to himself about the patient (or, if he relies on reverie, letting himself drift away momentarily), rather than being fully present with the patient in the room – which precludes the analyst from being able to relax. Instances when the analyst appears to be thinking to himself (or shows evidence of having done so, given the interpretation he brings back from such acts of introspection) can trigger intense anxiety and rage, since these instances are experienced by the patient as a betrayal of the analyst's imagined pledge to remain *fully present* with the patient in the here-and-now, with the analyst's thinking representing a failure to do just that. This idea borrows heavily from a paper by Britton (1989), in which he described his treatment of Miss A., the woman who responded to his interpretations by screaming her demand that he "stop that fucking thinking" (p. 88) because she experienced his interpretations as if "*I was eliminating my experience of her in my mind*" (pp. 88–89, italics added). Britton's interpretations left the patient feeling excluded *to the point of not existing*.

A point only alluded to in this chapter, which is worth highlighting in this introduction, is the extent to which elaborate psychoanalytic theories of the sort Britton developed to explain Miss A.'s intolerance of interpretations can oftentimes prove hard to put to good clinical use when the analyst tries to do just that. This isn't to say these theories aren't of considerable use to the analyst; it is only to note that there are times when what these theories reveal to the analyst cannot then be revealed to the analysand as such, though the understanding gleaned from the interpretation may go a ways toward helping the analyst withstand and contain rigorous clinical conditions. It is worth noting that what most people readily remember and quote from Britton's paper (e.g., Aron, 1995; Astor, 1998; Caper, 1997; Schoenhals, 1995) – his satisfying, understandable, and believable *symbolic* understanding of the patient's words "stop that fucking thinking" meant – was far beyond Miss A.'s capacity to grasp. Given what Britton went on to say, it can't even be said for sure that the patient's words had meant to her what they had meant to Britton. Britton knew better than to try and convey to the patient his understanding about what "fucking thinking" meant, having concluded that the only way he could proceed was to *keep his thoughts* to himself "whilst communicating to her *my understanding of her point of view*" (p. 89). So, as comprehensive and sophisticated as Britton's theory proved to be, he could find no way to introduce his theory into the treatment and, accordingly, had to settle with making the most of a difficult situation, thus illustrating an all-too-common phenomenon whereby elaborate conceptualizations about unfolding clinical events may not lend themselves to being effectively fashioned into an effective interpretation that furthers the analysand's understanding of herself.

Chapter 6 addresses a clinical approach to the treatment of patients who, like those described in the preceding chapter, find interpretations hard to handle. Rather than suffering from intense separation anxiety, these patients

exhibit the tendency to think concretely. Concrete thinkers have impaired ability to think symbolically and self-reflectively about themselves and about the nature of their thinking. These patients lack the capacity to shift their attention into "meta" mode – into a position from whence they might observe their thinking (engage in metacognition) and think about their thinking. Being able to do so requires an individual to have enough ego strength to be able to split his ego sufficiently to then be able to momentarily step outside himself and join the analyst in the exercise of mutually considering their own interactions as well as the separable behaviors of each. Theories that have been offered in the past to account for concrete thinking include defenses against symbolization (against forming symbols, linking symbols, and/or understanding symbols) and failures to properly differentiate fantasy from reality, self from other, signifier and that which is signified. To this list of candidates responsible for concrete thinking this chapter proposes a third candidate: the lack of a sufficient "theory of mind" – an inability to fully and more or less consistently appreciate the representational nature of the mind, which can arguably be thought to lie at the heart of concrete thinking. Theory of mind is a branch of academic cognitive psychology that's assumed the mantle as the leading perspective on cognitive development – a distinction that had previously been held by Jean Piaget and his followers for several decades. Theory of mind research outlines the developmental stages that culminate in one's ability to understand and appreciate the representational basis of the mind – that minds represent rather than reproduce external reality. The chapter concludes by stipulating the sorts of technical modifications needed to treat patients whose thinking tends to be more concrete. Modifications include a shift in emphasis – downplaying interpretations in general, and transference interpretations in particular, while inviting patients to focus more on the general workings of their mind – to rely more heavily on *metacognition*.

The third section of the book contains three chapters, each addressing technique from the vantage point of different psychoanalytic perspectives – the interpersonal (Chapter 7), the self psychological (Chapter 8), and that of the British Middle School (Chapter 9). It is unfortunate that some analysts who hail from certain schools of thought tend to keep to their own. While this is obviously an overstatement, it nevertheless captures a phenomenon that happens often enough. Analysts oftentimes publish articles in journals that chiefly cater to like-minded analysts, thus limiting the amount of cross-fertilization that might otherwise have taken place and would have enriched the field if only certain analysts would transcend parochial tendencies by availing themselves of the broader literature. Richards and Richards (2015) noted this phenomenon after discovering the contributions of Benjamin Wolstein – a man whose work they were late in reading; a man who they recognized as being "way ahead of his time" (p. 242). These authors attribute their not having read Wolstein earlier to the fact that Wolstein publishes exclusively in *Contemporary Psychoanalysis* – an interpersonal journal. "We

are trying to convey a sense of what has been lost to the psychoanalytic community as a whole," lament the authors, "by these decades of estrangement [between schools of thought]" (pp. 233–235).

Richards (2015) traces the problem back to the exclusionary politics of A.A. Brill who fought to restrict psychoanalytic training to those with medical degrees during the early days at the New York Psychoanalytic Institute, which – Richards argues – had "enduring institutional effects" (p. 27). But certain present-day conditions must certainly perpetuate the problem. Maybe analysts limit the breadth of their reading because there is far too much to read. Maybe some steer clear of journals they anticipate contain papers that are out of keeping with how they themselves think and practice. This tendency is aggravated, I believe, by the tendency of certain writers to rely heavily on the terminology most closely associated with a given school of thought, which has the unfortunate effect of triggering a knee-jerk reaction in readers who find the language off-putting and who are then apt to set the paper down rather than forge ahead. For example, to this day I am amazed to have heard Robert Stolorow declare, in no uncertain terms, that there is no such thing as projective identification. Though the phenomenon described by that terms is called by other names by other schools, there is widespread belief that such things do in fact happen, as we will see in the first of these three chapters, which focuses on the thinking and clinical approaches of those from the interpersonal school. It is opposition to such parochialism that leads me to this section of the book.

Chapter 7 compares the understanding and technical management of countertransference enactments from a few different psychoanalytic perspectives, with special emphasis on how analysts from the interpersonal school have come to think about and treat such enactments, which differs considerably from how more classically oriented analysts approach the subject.

Chapter 8 addresses an aspect of self psychological theory that has to do with the relationship of analyst-induced empathic failures and "transmuting internationalizations" (Kohut, 1971), which are thought to come about after a series of such failures have successfully been worked through. This chapter, previously published as a paper in the mid-1990s, represents my understanding at the time of the role empathic failures played in self psychological theory. Whether the position I'd taken back then holds up now is for the self-psychology-savvy reader to judge. Back then, I had the impression that self psychologists had overlooked certain complexities in its thinking about empathy and empathic failures, and I wrote this paper in reaction to what I saw as an over-emphasis on the importance of empathic failures, which represented yet another pendulum swing in theory creation. In this chapter, I argue that as vital as empathy is, to the extent it may provide the necessary selfobject ingredient that had been pathogenically missing during a patient's formative years, some patients are not keen on the analyst's display of empathy. Beside the question of whether empathy is universally welcomed is the complex question

of which aspect of the patient's experience takes preference when the analyst endeavors to offer his empathy. Attempting to empathize simultaneously with different aspects of the patient can prove to be an impossible task. How do we as analysts decide which of the patient's current experiences deserves foremost attention? Do we empathize with patients who need us to be emotionally drawn in to the point of enactment, or with patients who need the reassurance that we have not been injured by their behavior? Do we empathize with patients as they are, or with who we believe they are on the way to becoming (Loewald, 1960)? Do we empathize with patients who are grandiose (and feel *so* different as to be unfathomable to others), or with patients who yearn to be fathomed but fear becoming ordinary as a result (Kohut, 1971; Tuch, 1993)?

Chapter 9 addresses technique from the vantage point of the British Middle School highlighting the work of W.R.D. Fairbairn, Donald Winnicott, and John Bowlby and addressing commonalities in how these theorists viewed the effect of environment on the developing individual and how those theories translate into particular types of treatment approaches outlined in this chapter.

The fourth section of this book – which focuses chiefly on pedagogy – contains three chapters, the first two of which address teaching from different angles. Chapter 10 focuses on the teaching of psychodynamic psychotherapy to students enrolled in psychotherapy training programs at our nation's psychoanalytic insititues and Chapter 11 examines styles of supervising case work. The final chapter educates our psychoanalytic candidates and our psychotherapy students, who often feel besieged by the charges leveled by our most vocal and harshest critics, who claim, in the face of evidence to the contrary, that psychoanalysis lacks scientific backing.

Chapter 10 addresses both the needs of those wishing to expand their clinical skills by learning more about how to conduct psychodynamic psychotherapy as well as the needs of analysts wishing to teach these students. This chapter serves as a primer for students new to the field and it also provides an outline of topics and a list of suggested readings for instructors who want to educate students about the methods of psychoanalytic psychotherapy.

Chapter 11 addresses the varying styles used by analysts in the course of supervising cases. The chapter presents a somewhat controversial thesis: the supervisor is better situated than the supervisee to be able to make out the dynamics of the case and to ascertain the nature of what is going on between the supervisee and his patient; on the other hand, the supervisor is poorly positioned to know how to make the best use of this knowledge in the actual treatment setting. Such ideas can substantially effect how supervisors go about conducting supervision.

While this book chiefly addresses controversies about psychoanalytic technique, we cannot ignore controversy within society at large about whether psychoanalysis is a viable, worthwhile, and effective form of treatment, which is the main topic of the last chapter of this book. Historically, psychoanalysis

has been dogged by questions about whether it is scientifically based, and in the spring of 2015, that challenge suddenly intensified with the publication of claims made by two noteworthy experts: one was leveled by Jeffrey Lieberman, Chairman of Columbia University's Department of Psychiatry, who charged psychoanalysis with being "dogmatic and anti-scientific" (Lieberman, 2015, p. 69); and the other was made by Edward Shorter, Professor of Medical History at the University of Toronto's Department of Psychiatry. who likened psychoanalysis to "witchcraft" and called upon psychiatric training programs to "abolish psychoanalysis from the psychotherapy training of residents," positing that psychoanalytic instruction was "like making a course in astrology requisite for the training of astronomers" (Shorter, 2015). The publication of these opinions served as impetus for the writing of Chapter 12, which reviews in some depth the studies and meta-studies that scientifically establish not just the efficacy of the practice of psychoanalysis but, furthermore, scientifically validate several of the field's core assumptions about repression, the unconscious, the existence of unconscious motivation, and the like. This chapter also contains a review and rebuttal of the theories of Adolf Grünbaum (1976, 1977, 1981, 1984, 1993, 2006), a widely respected philosopher of science who has dedicated enormous amounts of time and energy to "proving" that psychoanalysis fails to meet criteria that would earn it the right to be truly considered "scientific." The chapter ends with an examination of the concept of "scientism" – the tendency to believe that questions about all matters can simply be settled by applying the scientific method, which leaves us to wonder about the extent and limits of the domain about which science itself, and psychoanalysis in particular, can claim authority.

The subtitle of the final chapter, "Truth comes in many colors," pays homage to Roy Shafer (1996), who wrote: "There is plenty of truth. It is just that truth comes in different versions. It always has" (p. 251). This book aims to address the nuances of treatment from many different perspectives. Hopefully, it will contribute to the ongoing debates about technique, which should help further our field by improving our collective understanding of how one goes about conducting psychoanalytic treatments. There are a wide array of opinions about how one conducts psychoanalysis, and these differences issue, in part, from different background theories held by different schools of thought. These theories, in turn, direct the analyst's attention to different sorts of clinical phenomena that he will then use to arrive at an understanding of who the patient is and what he is about. I find it hard to declare a winner in the race to prove one theory superior to all others. Efforts to do so are made to seem all the more ridiculous when one realizes that the theory a given analyst picks as his own is largely a function of who he is as a person, so arguing that an analyst "ought" to do this or that at a given point with a given patient makes little sense if one isn't personally inclined to work in the fashion being prescribed by the critic who's spelling out his view of how psychoanalysis should be conducted.

Whether or not such a thing as common ground exists, I do not believe we need be discouraged by seemingly irreconcilable differences between our most revered theoreticians and clinicians. Grotstein was keen on being psychoanalytically multilingual, and while some argue that switching back and forth between differing theories when treating a given patient might prove counterproductive and confusing for the patient, there are others who continue to believe that one is better off having several viewpoints to pick from one's quiver than sticking with one theory come hell or high water.

Notes

1 For those doubting my claim, evidence will be provided in Chapter 3.
2 The analyst continues to satisfy the criterion, outlined by Bion, requiring that they enter each session without memory or desire – which does not mean that background theory does not play an active role in implicitly directing the analyst's attention.