Practical Psychoanalysis

By now, the term practical psychoanalysis has become an oxymoron. The way psychoanalytic treatment is generally conducted, it is extremely impractical: it doesn’t serve the needs of the vast majority of potential patients. Understandably, people who seek the help of mental health caregivers want a therapy that will provide maximum relief from emotional distress as quickly as possible. Most clinical psychoanalysts offer instead a lengthy journey of self-discovery during which too much concern with symptom relief is considered counter-productive. “Self-awareness” is the main goal; symptom relief is of secondary importance and is expected to arrive, if at all, only after a while.

No surprise, then, that psychoanalysis has come to be regarded by the public at large as an esoteric practice that promotes a self-involved escape from real life, rather than a treatment method that helps the patient live real life more happily. No surprise, either, that all over the world fewer and fewer patients seek psychoanalytic treatment, and that those who do are for the most part people who want to become psychoanalysts themselves or fellow travelers who have
an intellectual interest in the field. Clinical psychoanalysis has become, deservedly, the stuff of New Yorker cartoons.

This unfortunate state of affairs is ironic, considering that psychoanalysis got its start on the basis of its therapeutic efficacy. In the course of their researches, Breuer and Freud stumbled upon a method for relieving notoriously difficult-to-treat hysterical symptoms. Though Freud was a fascinating and imaginative writer who developed far-reaching ideas about culture and society, as well as about individual psychology, the world originally paid attention to him because of the extraordinary cures he and Breuer achieved—and achieved very rapidly, too, in contrast to the expectations of contemporary psychoanalysts.

Over the years, psychoanalysis drifted away from its original orientation toward symptom relief as the desired outcome of treatment and became increasingly preoccupied with a special, specifically psychoanalytic goal: the achievement of “insight” for its own sake. In the process, psychoanalysts not only made themselves irrelevant to most people’s needs, but, as many critics have pointed out, also compromised clinical psychoanalysis as a scientific investigative tool. How can the validity of insight be assessed? Insights reached by analyst and patient together about the latter’s psychology are inevitably influenced by the former’s theory. Therefore, unless insights are validated by correlation with symptom relief (an outcome criterion that is not theory-driven), a closed system is set up in which successful clinical analysis consists of analyst and patient discovering what the analyst assumed a priori to exist. Impractical psychoanalysis is also unscientific psychoanalysis.

Clinical psychoanalysis has become impractical, but it does not have to be impractical. In order to offer patients practical psychoanalysis, however, clinicians cannot conduct treatment on the basis of received wisdom. To begin with, psychoanalysts cannot assume the virtue of any particular set of procedures—use of the couch, frequency of sessions, even the method of free association. These are techniques, and in the progressive development of any scientifically based clinical practice, techniques will alter, even alter dramatically, as empirical evidence accumulates; some prove valuable and are retained, others
are discarded. Only two hundred years ago, for example, the best available medical science indicated that bleeding the patient through use of leeches or by venicotomy was part of the responsible standard of care for most illnesses. Almost every patient who consulted a physician was bled. We now know that this technique, which was practiced as state of the art by the best physicians for centuries, was useless in almost all cases and dangerously detrimental in many.

Similarly, we have every reason to expect that the techniques of a scientifically based clinical psychoanalysis will alter over time. Therefore, it makes no sense to define clinical psychoanalysis as a particular set of techniques. Nor does it make sense to define clinical psychoanalysis as a particular set of theories, for these, too, will alter as science progresses. Even the most fundamental psychoanalytic concepts and principles should be critically reviewed at every turn, and we can anticipate that most will eventually be found obsolete. That’s what happens in science. Practical psychoanalysis means remaining open-minded with regard to theory, holding nothing as axiomatic; and it means retaining an experimental approach to technique—that is, searching for whatever way of working together with a given patient seems to make progress toward the desired goals of treatment.

If practical psychoanalysis cannot be defined in terms of any particular theory or technique, how can it be defined? The sensible way to define practical psychoanalysis is in terms of its area of study and its objectives. Sciences are usually defined in terms of their subject areas and applied sciences in terms of their objectives (e.g., chemistry is the study of compounds, and pharmacetics is the creation of useful drugs by applying chemical knowledge). Psychoanalysis is a scientific study of the mind, and clinical psychoanalysis is an application of psychoanalytic science to therapy. Practical clinical psychoanalysis is a treatment that aims to help the patient feel less distress and more satisfaction in daily life through improved understanding of how his or her mind works. Another way to put this is to say that in a successful practical analysis the patient is able to revise various aspects of the way he or she constructs reality, with the result that the patient feels better.
We might even take a traditional view, following Freud, and add that practical analysis brings the unconscious into consciousness. However, if we want to continue to use that conception, we must be prepared to update our definition of “the unconscious.” It was Freud’s idea that clinical psychoanalysis brings into conscious awareness certain thoughts that are available to consciousness but remain unconscious because the patient is motivated not to be aware of them—what Freud termed repressed thoughts or the dynamic unconscious. And it is true that successful practical analysis usually does, to a certain extent, involve the patient identifying ideas, feelings, and memories that he or she has been holding out of conscious awareness for one reason or another. But it is also true that a very significant part of what happens in practical analysis consists of the patient becoming conscious of thoughts that have never been repressed, thoughts that the patient simply never had the opportunity to think before. These thoughts arise from novel perspectives provided by the analyst—explicitly or implicitly, intentionally or unintentionally—in the course of an intimate, mutually engaged exploration with the patient of his or her difficulties.

In every professional community, there are some psychoanalysts who treat patients practically. These clinicians help their patients achieve therapeutic benefits as rapidly as possible. The patients feel better, the quality of their lives improves, and their friends and families can see it. For that reason, practical psychoanalysis, contrary to the general trend, have more referrals than they can handle—and their practices are filled with patients who are neither analysts in training, nor hapless souls who are encouraged to remain for many years in treatments that produce no significant symptom relief.

Unfortunately, practical psychoanalysts tend not to publicize what they do with patients; instead, they quietly set many traditional psychoanalytic theories and techniques aside and go about doing what works. Good for practical psychoanalysts and for their patients! But not good for the field. There are many clinicians who would like to learn more about how to conduct a practical psychoanalytic treatment, and many patients who would like to know how to recognize one. This book is addressed to readers in both categories.

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In the chapters that follow, I will discuss what I have found to be basic principles of practical psychoanalytic treatment. I will use a casebook format, presenting concepts via illustrative clinical examples. I do that for two reasons: first, because I find that abstract formulations about psychoanalytic theory and technique, by themselves, are difficult to understand, let alone apply on the line in work with patients; and second, because my recommendations are not based upon findings from systematic, controlled empirical research (nobody's recommendations are, in psychoanalysis, since adequate research methods have not yet been developed) and I want to share with readers, as best I can, the clinical experiences that have led me to reach my conclusions.

This is not intended as a scholarly volume. I haven't presented a survey of the literature, noting whose ideas have been the same or similar to mine and whose have been different. No background in psychoanalysis is required to understand what I have written. When I speak of an "analyst," I do not refer to someone who has attended an official psychoanalytic training program; I only mean a psychoanalytically informed psychotherapist—and since most of Freud's important ideas have long since percolated into the cultural surround, any contemporary psychotherapist who is at all eclectic in his or her orientation will inevitably be psychoanalytically informed. My aim is to discuss in a down-to-earth way what, in my experience, can be useful for both analyst and patient to keep in mind when collaborating in an effort to help the latter feel better; and I think the best way for me to do that is to offer a collection of anecdotes, together with my thoughts about them.
You can't treat a patient successfully without knowing what it is you're attempting to treat the patient for, and it's impossible to judge the progress of a treatment unless you know what the desired outcome of the treatment is supposed to be. Therefore, the crucial first step in doing effective clinical psychoanalytic work is to reach an understanding with the patient concerning what his or her symptoms are and what symptom relief would consist of.

By *symptom* I mean something about himself or herself that the patient needs to change because it is causing distress. It is the *patient* who decides what his or her symptoms are. This point cannot be overemphasized. Certainly, the process of identifying symptoms is a collaboration between patient and analyst, to which the analyst can make important contributions; but it is the patient who must have the final word, because clinical analysis doesn't work when a patient is being treated for something the patient doesn't regard as a problem—even if the analyst is convinced that it is a problem. Impasses in analysis often arise because an analyst is attempting to treat a patient for what the analyst thinks the patient's symptoms are, without...
having carefully explored the patient’s view of what his or her symptoms are. Then, analyst and patient mistakenly assume that they are pursuing a shared objective, while in fact they have quite different ideas about symptoms and symptom relief. They work at cross purposes for some time until, eventually, the misalliance makes itself felt; and even when it does, they may not realize that a fundamental lack of consensus about the goals of treatment is responsible for their problem. The old light bulb joke says it well: How many psychoanalysts does it take to change a light bulb? Only one, but the light bulb has to want to change!

It is by no means necessary that a patient arrive with a clear idea of what his or her symptoms are in order to be treated. Very often a patient seeks help without any definite notions at all about how he or she needs to change. The patient only knows that he or she feels bad and wants to feel better. When this is the case, the first order of business is to achieve some clarity and consensus about what the patient’s symptoms are and what symptom relief would mean. That task is often not easy to accomplish. Sometimes, the work needed, in itself, brings significant therapeutic benefit.

For example, some patients admit willingly that they need help, but when they describe what they need help with, their problems always turn out to be externally caused—by unsympathetic spouses, abusive coworkers, physical illnesses, or other circumstances outside their control; they see nothing about themselves that is responsible for their distress. Or, the exact opposite can be the case. Some patients are desperate to find pathological character traits in themselves that they can work on in analysis, because they want to avoid at all costs acknowledging that their distress arises from external circumstances—abusive partners who won’t change, children in trouble whose disturbances they want to minimize, or other facts of life that they’re reluctant to face. When a patient whose presenting complaints are based on externalization or on denial is eventually able to become clear about what his or her symptoms are, the recognition, in itself, can represent a significant achievement that brings with it considerable therapeutic benefit.
It sometimes happens that a patient is uncertain about what he or she wants to work on, and sorting out that uncertainty turns out to be all that was needed. Here is an example.

RALPH

One evening, I ran into a friend of mine at a party. The successful CEO of a large company, he was extremely skeptical about psychotherapy; so it was with a kind of grudging amusement that he said he had a story to tell me that he thought I would enjoy hearing. He had just had the pleasure of hiring for a very well-paid position a man named Ralph, whom he had known fairly well at one time, but had not seen for ten years. My friend was astonished at how Ralph had changed. Ten years ago, Ralph would never have been able to handle significant managerial responsibility. He had always been bright, but terribly depressed and ineffective. His personal life was a mess—he seemed henpecked and miserable. But now, Ralph was obviously on top of things in a very nice way. No more wishy-washiness: he was straightforward and clear. Whereas Ralph used to be self-effacing to an infuriating degree, and would endlessly qualify everything he said, he now came across as appropriately thoughtful and modest, but confident. As they caught one another up on their personal lives, my friend noted that Ralph spoke about his wife with unmistakable pleasure and affection.

So impressed was my friend with this apparent transformation that he was moved to comment on it to Ralph and to ask how it had come about. “I had a very good psychotherapy,” was the answer. “I found a shrink who helped me figure out the things I needed to know about myself.” Thinking that he might like to refer somebody some time to a therapist who actually helped people, my friend asked the shrink’s name and was surprised to learn that Ralph had been in treatment with me. I was quite gratified by this coincidental report, of course. But what particularly interested me about it was something that Ralph had not mentioned: the very helpful psychotherapy
with me that Ralph described to my friend had consisted of only one visit!

I remembered the session very well. When he had come to see me, Ralph had seemed very much as my friend described him having been years ago—troubled and tentative. Ralph talked about his general malaise, his problems at work, his marital difficulties, his fear that he was an inadequate father to his two children, and a host of related worries. He told me a bit about his background, hesitantly sketching out what I thought were probably some very shrewd insights about his mixed feelings toward a loving but somewhat dictatorial father, his conflicted identification with a quietly competent mother, and his anxieties about a younger sister who adored him.

After a time, I asked Ralph what he wanted to accomplish in therapy. He thought a moment, then answered in a way I could not possibly have foreseen. He said that what he would really like to do was to feel able to devote a year to studying guitar. Apparently, Ralph was quite a talented guitarist and passionate about the instrument. He could practice for hours without noticing the time go by. He played jazz and was good enough to sit in at clubs on open-mike nights; but he had never had any formal training, and he knew that his level of playing would improve enormously if he could spend a year consolidating his skills through study at a conservatory. He was pretty sure he could get into a good one.

Ralph did not know where this would lead; certainly, he did not expect to make a living as a professional musician, but he knew he wanted to take his guitar playing further. At the same time, he knew that to do so would mean earning no money for a while. His wife’s small salary would not begin to support the family. They would have to use up their savings, and there was a very real possibility that Ralph would be unable to find another executive position when he reentered the marketplace. Ralph felt himself on the horns of an insoluble dilemma: he did not want to put his wife and children at such risk, despite their assurances that they would support him if he needed to drop out for a year; on the other hand, he remained preoccupied,
distracted, and upset because nothing in his life seemed worthwhile if he could not pursue his dream.

Listening to all this, I had the impression that Ralph was not really describing a choice he was trying to make. It was more that he was describing his reluctance to act on a choice that he had already made. It seemed clear that he felt he could not be happy without studying the guitar, and that he could not study the guitar without asking his wife and children to endure a certain amount of sacrifice and risk. I conveyed this impression to Ralph, and he agreed. I asked him if he felt he had the right to do what he wanted to do. He thought quite a while before replying, and finally said that he was not sure. Probably, he did; but, in any case, he was making himself and everyone else so miserable by not doing what he wanted, that, practically speaking, there really was no good alternative. Still, he felt unable to act.

I said that there were certainly a great many relevant matters we could explore—how Ralph seemed to be looking for permission from me or some other authority; particular problems he had in balancing self-interest against a sense of responsibility toward loved ones; the special meaning that artistic creativity as opposed to business held for him; and so forth. If issues of this sort were making things more difficult than they needed to be, it would be very useful for us to investigate them together; but it was also important to keep in mind that no amount of self-awareness was going to change the circumstances with which Ralph had to deal, or the need for him to act, one way or the other, and to take responsibility for his actions. It might simply come down to a question of Ralph’s having to accept that he had to do what he thought best under the circumstances—one way or the other—and live with the consequences, not all of which would be agreeable.

As I laid out the way I saw the state of affairs, Ralph kept nodding thoughtfully in agreement. Our time was about up, so I suggested that we arrange another appointment to continue to reflect and decide how Ralph might want to proceed. He agreed. The next day, however, Ralph called to say that I had given him a great deal to think
about and that for the moment he felt he did not need to chat further. He would certainly give me a call when and if he did. He thanked me warmly and said that he would like to stay in touch, in any case. I asked him to please keep me posted.

A month or so later, Ralph left me a message that he had decided to take the plunge, to study guitar, and that he thought things were going to work out. For a few years, I received occasional notes telling me that he was doing well. Eventually, I learned that he was back at work and enjoying keeping up on guitar. After a while, I stopped hearing from Ralph, so that my friend's anecdote was a very welcome update.

One way to think about Ralph's single session treatment would be to say that he found out that he didn't have any symptoms. Our brief exploration of his desires and conflicts helped him see that there was nothing he could change about himself that would alter his dilemma. He simply had to make a decision and act on it, difficult as that was. Another way to think about Ralph's treatment would be to say that he got clearer about what his symptoms were: his reluctance to acknowledge that he had to make a decision and act upon it, and his unrealistic hope that he could somehow change the terms of the conflict he was facing.

I think an argument could be made for either view, and I'm not sure it matters which we choose. The important point is that it was my asking Ralph what he wanted to get out of treatment—my inquiry into what Ralph thought his symptoms were and what kind of symptom relief he was after—that produced the positive therapeutic result. It set in motion a process of self-investigation (which Ralph conducted largely on his own, not with me) that concluded very happily for him. It hardly matters whether we say that Ralph reached the conclusion that he had no symptoms, or we say that he reached an understanding of what his symptoms were and became able to deal with them effectively. What matters is that Ralph's and my collaborative effort to identify his symptoms, brief as it was, made possible what was, as Ralph said, a very successful psychotherapy.
Ralph's treatment also illustrates very clearly something that is often not so obvious, but that nonetheless always applies. In every successful analytic treatment, a significant part of the work is done by the patient on his or her own, and may never be shared with the analyst. And that is as it should be. An analyst's task isn't to present truth to the patient. An analyst's task is to stimulate a learning process in the patient, by means of which the patient can discover his or her own truth and put it to good use.
Once an analyst and a patient have agreed about symptoms, they can undertake an investigation that has as its goal symptom relief. Every clinical psychoanalysis is an inquiry, an attempt to answer the questions: What is it about the way the patient constructs his or her experience that causes the patient to suffer? Which of the patient’s assumptions, conclusions, and expectations need to be reviewed and revised so as to relieve the patient’s distress?

But a clinical psychoanalysis is not only an inquiry. Understanding the nature of the problem is only half the task. A remedy has to be provided, as well. The patient has to be helped to find new ways of operating to put in place of old, maladaptive ones. A clinical analyst’s job is not merely to reveal problematic parts of the patient’s mental life; it is also to alter problematic parts of the patient’s mental life.

In practice, these two aspects of the analyst’s job converge. While collaborating with a patient to conduct an inquiry into the nature of the patient’s problems, an analyst communicates his or her own point of view, different from the patient’s: At times, an analyst may offer his or her ideas explicitly, but even when the analyst is only asking
questions, the analyst's questions are informed by his or her particular interests and hypotheses. The patient may agree with the analyst's perspective, may disagree, or may be uncertain about it. Whichever the case, the analyst's input is aimed at helping the patient to extend his or her thinking. Confrontation with a different point of view allows the patient to clarify what his or her own way of constructing reality has been; it helps reveal the problem. At the same time, confrontation with a different point of view allows the patient to consider alternatives to his or her customary ways of thinking; it helps remedy the problem. An analyst communicating his or her own take on a patient's experience often has an investigative and a therapeutic effect, simultaneously.

Common sense, not to mention reasonable modesty, direct an analyst to avoid rushing right in with ideas for the patient to consider. Nonetheless, from the very start of clinical work there are opportunities for an analyst to contribute, respectfully and productively—especially if the analyst offers his or her ideas for what they are: not authoritative, disinterested truths, but inevitably subjective perspectives on the matters at hand. I made several comments to Ralph (see Chapter 2) during our meeting that obviously reflected my own conclusions based on my personal experience. The interactions between Ralph's ways of looking at things and mine were clarifying for him—and therapeutic, as well, as it turned out. Ordinarily, though, productive interactions between the analyst's perspectives and the patient's that occur early in analysis are less conclusive than was the case in Ralph's treatment; they are usually part of a more extended process of defining symptoms and symptom relief, and of beginning to map out areas in need of exploration. Following is an account of the first session of a treatment that went on for several years.

SHEILA

Sheila consulted me because her previous therapies hadn't helped her. In those therapies she developed complex, emotionally charged relationships with her therapists and examined the relationships carefully.

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Sheila felt she learned things about herself, but her life had failed to change for the better. What did she want to change about her life? I asked. Sheila wasn’t sure: she wasn’t sure what she had been looking for from treatment in the past, or what she was looking for now. She knew she wanted to be rescued, but she wasn’t certain what she wanted to be rescued from. Loneliness, maybe. She knew that in the past she had used therapy to provide herself with a relationship. Buying a relationship isn’t a good reason to be in analysis, she said sadly. I asked Sheila what she thought would be a good reason to be in analysis. That’s a hard question to answer, she responded.

Sheila ruminated around, discussing her marriage and how it had gone bad. Her ex-husband was an underachiever, dependent and depressed. After a few years, she’d gotten tired of taking care of him. Now she was alone at age fifty, and she wanted to feel more connected to people. But she couldn’t say what prevented her from feeling more connected to people. I suggested to Sheila that our first order of business should be to look into her difficulty knowing what it was that she might want to change about herself, what would be a reasonable objective for her therapy. She agreed that might be a useful focus.

Sheila thought about how isolated she felt. She told of an Asian woman, Suzanne, in whom she became interested because she wanted to learn all about Suzanne’s culture. As soon as Sheila had learned a good deal about the Asian culture, she lost interest in Suzanne. Sheila began to spend less time with Suzanne, who was hurt by the withdrawal. Sheila felt bad about that. I asked Sheila if she believed that she hadn’t the right to follow her real interests. Did she think that her decision not to spend time with Suzanne out of obligation meant she was not a good person? Sheila answered that she assumed she was bad for withdrawing from her friend, and Sheila was surprised that I seemed to be questioning her assumption.

Now Sheila began to talk about Carol. Her relationship with Carol was probably the most important one in her life. Sheila had been withdrawing, too, she believed, from Carol, now that Carol was planning to move to the suburbs with her boyfriend. Sheila felt that she was not nice to Carol because Sheila resented the geographical
distance Carol's move would create; and she resented, too, Carol's dependence upon her boyfriend. Sheila pursued the idea that she was not nice for resenting Carol in this way. Sheila talked about how controlling she was, noting that she frequently lectured Carol.

I said to Sheila that it might well be helpful for us to question on a pragmatic basis the attitudes that she criticized in herself—to ask whether they contributed to her distress—but I was not sure I understood what she saw as the moral issue involved. Sheila was surprised by my comment and interested in it. She considered the moral dimension of her relationship with Carol. Evidently, Carol was an ex-prostitute who had been very druggy at times in her life. Sheila really got on Carol's case. Sometimes Carol resented it, but she appreciated it, too. To me, it actually sounded like a nice quid pro quo between Sheila and Carol: Sheila got to feel like an important caretaker, and Carol got the care she needed. I said this to Sheila, and she responded by telling me that after attending a Jesuit college, she had entered a convent. She became a nun and was part of an order whose mission was to care for delinquent girls.

Sheila then talked about why she had become a nun. The eldest of six children, she knew she did not want to be barefoot and pregnant like her Catholic mother, nor did she want to submit to her father's intimidating rages. He was a bully, but a charmer. Sheila talked at some length about her father's appeal, as well as about his temper tantrums.

Still, she said, she just did not feel that she was a nice person. She argued with motorists who cut her off, exhibiting a kind of "don't-fuck-with-me" attitude. Sheila felt bad when she did that. It wasn't grown up; she thought she ought to be different. I asked her if she felt like her father when she lost her temper. She certainly did, she said. I pointed out that apparently there were some good things about her father and some bad things. I said I thought that Sheila needed to criticize herself when she imitated bad things about her father, but not when she put to use good things that she learned from him. Deciding which were which was an important sorting process, and not always an easy one.

Sheila agreed, realizing that she had always been on a moral quest when she had been in therapy before. My approach seemed different from her previous attempts to find some way to know how to do something to provide some sense of moral good.

I said that felt good for treatment, for an authoritative sense that she had been informed this, telling her that she had actually seen her analyst meant something to her. Okay, she would have to change then self unrealistically, and change it. Sheila willed herself to a very good place, feeling that was different, having bought into the journey into her past.

Instead of inviting her my own ideas, she thought about what she was burdened with. Finally, her thought was the depiction of the gay side, where people were different. She chuckled, thinking of the scene in the B received morality by that she liked Bunue doxy. She had the in
Carol's decision to find some way to feel like a good person, something she had not known how to do since she gave up her religion, led her to seek treatment for an authoritative judgment from the analyst. She had the impression that she had been looking for that in her prior treatments. The analyst had informed her that she had always started out that way, but eventually saw her as someone who always started out that way. The analyst had told her that she had been looking for that in her prior treatments. She had the impression that she had always started out that way, but eventually saw her as someone who always started out that way. The analyst had told her that she had been looking for that in her prior treatments.
treatment with me; she wished she had worshiped less in previous treatments.

We were nearing the end of our time, and Sheila remarked that she thought it had been a good session. It felt like what we did had been for her, not for me. She realized how much she had always deferred to her analysts—at least at the beginning, before they fell off their pedestals. She always assumed that she would have to be in treatment all her life in order to remedy her moral faults. Now she thought she had a choice about whether she even needed to be in treatment at all. Maybe if she thought more often that she had choices, she wouldn't get so angry; and maybe, if she weren't so angry so much of the time, she wouldn't feel like such a bad person. Sheila started crying, aware that at the moment she was more sympathetic to herself than she could remember having been in a long time. She had spent so much of her life feeling resentful about being oppressed, she reflected. That had caused her to get rebellious and disobedient, which only further convinced her that she was a bad person. She had always been angrily trying to break out of prison. Now she thought that maybe the prison had been one of her own making, by moralizing against herself.

The way Sheila presented herself and described her reasons for seeking treatment exemplifies the very common clinical situation in which a patient arrives, feeling in need and asking for help, but having no clear idea of what his or her symptoms are or what a reasonable goal for treatment might be. The most Sheila could say was that she wanted to be rescued from loneliness. She did not know what was causing her to remain lonely; she identified nothing specific about herself that needed to change. As I told Sheila, and it made sense to her, the first thing we had to do was to try to understand why it was so difficult for her to be clearer about what she felt was wrong and what she might expect from treatment. Obviously, I was beginning an inquiry. But I was beginning the inquiry by stating an opinion of my own, and I continued to communicate my opinions, implicitly and explicitly, throughout our meeting.

In an effort to help Sheila become clearer about what her symptoms were and what symptom relief would be, I asked Sheila a num-
ber of questions she could not answer. I told Sheila that time and the passage of time would be needed to get a clear picture of the situation between her and her analyst. I said that her treatment about personal experiences was a sign of progress. When I saw her again, she said she felt a little less angry. By the third session, she had developed an intellectual evaluation of the treatment. I told her that she was an intellectual analyst and that she needed to make his own understanding of the situation more relevant, did relationships to recognize identification.
ila remarked that what we did had not always been done, and they fell off after being. Now she thought she was in treatment at last, she wouldn't rush of time, didn't cry as often as she could, so much of her time had been wasted. That had only further convinced her that the prison inst herself.

reasons for seeking help, even after having no reasonable goal that she wanted at was causing herself to be difficult for what she might have been. But I was her own, and I was also implicitly, that her symp-

Sheila a number of questions, some of which she could answer and others of which she could not. There were also several times when I pursued our investigation by stating my own personal views— for example, when I told Sheila that she could only feel okay about herself by being her own authority, rather than by seeking the approval of others; or when I said to her that she would have to separate what she wanted to imitate about her father from what she did not. I didn't make value judgments about Sheila, but I did communicate opinions, based on my personal experience, concerning certain matters of importance to her. When I saw things differently than Sheila, it was obvious to her, sometimes even surprising, as when I questioned her assumption that she should feel guilty about spending less time with Suzanne. The interactions between our different points of view proved extremely productive. By the end of the session, Sheila had identified something about herself that she very much wanted to change: she wanted to discontinue her habitual, confining, self-punitive moralizing. And she had developed an idea of how symptom relief would feel: like being released from a prison of her own creation. Sheila hoped to feel freer, and therefore less angry and less rebellious. Sheila was getting clearer about what was wrong and what she was after, and we were on our way.

Traditional conceptions of clinical analytic technique direct the analyst to avoid being too active, especially at the beginning of treatment, and even more especially when activity involves the analyst making his or her own personal ideas known. Furthermore, focusing on symptoms and symptom relief is traditionally considered to be counterproductive because it is thought to encourage the patient to intellectualize, leading away from emotionally significant exploration of the treatment relationship, including transference analysis.

I find none of this to be true, and I think my first meeting with Sheila was an example in point. Actively pursuing with Sheila greater clarity concerning her symptoms and the symptom relief she was seeking, with me contributing my own opinions where they seemed relevant, did not distract Sheila from exploring the influence of past relationships upon her current life. Quite to the contrary, it led her to recognize—and recognize very quickly, all things considered—an identification with her father of which she had previously been
unaware. Moreover, Sheila was able to begin to see the role that her identification with her father, and her fear of it, played in her tendency toward harsh self-criticism.

Nor was this an intellectual line of investigation. Actually, it produced an intense affective response in Sheila of a kind of which she had been incapable for a very long time. Sheila began to explore our relationship in an emotionally meaningful way, looking into conflicts brought up by her urge to submit to me as she had submitted to others in the past. She was already engaged in transference analysis par excellence.

One final point about analyst–patient interactions early in treatment. The manner in which the interactions take place establishes, at the very beginning, ground rules that will have a decisive influence on all the work that follows. Consider how lost and confused Sheila claimed to be at the outset, how plaintively passive she was, but how quickly she became an active participant in our investigation. Initially vague and unforthcoming, by the end of the session she was able to articulate what she appreciated about me (the session felt like it was for her), what intrigued her but left her a bit uncertain (my pragmatism), and what worried her (she did not want to be seduced into worshiping in my church). She brought forward these aspects of her experience of our relationship, making them matters we could look into together.

A truly collaborative relationship, with patient and analyst on a level playing field, is a sine qua non for effective analytic treatment. Sheila and I were able to establish such a relationship very quickly. How did that happen, given the far from promising opening of the session? It was crucial that I consistently communicated to Sheila that she would define the goals of the treatment, she would decide for herself what her symptoms were and what we would aim for as symptom relief; I would not try to install myself as an authority on how she needed to change. A patient will only feel himself or herself to have an authoritative voice in the treatment relationship if the analyst invites it.

Also, a patient will only be truly candid in analytic treatment if the analyst is willing to be equally candid. It was very important that
I explained myself to Sheila as we went along, and did not hesitate to make my own point of view explicit. How a patient appears in treatment depends very much upon context. Initially, Sheila seemed helpless and opaque. Eventually, she revealed herself to be sharp and feisty. The transformation might not have taken place if I, as her analyst, had approached her in a less active and personally direct way or expected her to defer to my expertise.