CONFESSIONS OF A RECOVERING EGO PSYCHOLOGIST

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Abstract

This autobiographical paper attempts to show an evolution in the author’s relation to, and use of, psychoanalytic theories. Beginning in the USA, at a very traditional ego-psychological Institute, he has experienced disappointments and illuminations from various theories over many years. His experiences are recalled to illustrate how theory can orient, and confuse, a developing practitioner.

Confessions d'un ancien ego-psychologue

Ce article autobiographique tente de montrer une évolution en ce qui concerne la relation de l'auteur avec des théories psychanalytiques, et son utilisation. Débuté aux Etats-Unis, dans un Institut d'ego-psychologie très traditionnel, il a connu des déceptions et des éclairages des diverses théories depuis de nombreuses années. Ses expériences sont évoquées pour illustrer comment la théorie peut orienter, et confondre, un praticien en voie de développement.

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Introduction

This is the story of my evolution as an analyst, especially as I understand and relate to theory. As I narrate it, I will give a simplified and idiosyncratic history of some developments in the world of psychoanalytic theory, as seen from my vantage point in Eastern Massachusetts. I share this history with another agenda. I am trying to orient younger clinicians, especially those who get shy around theory, to a way to think about theory.

I am not a theoretician. I have always had an ambivalent relationship to theory. I prefer stories to theories. I was an English major. When I am reading papers, I have trouble with the theoretical part, and feel on more solid ground when I get to the clinical examples. As you will see, I like to use theory to help my clinical work, but I get my back up when I experience it as trying to push me around. Perhaps everyone has an ambivalent relationship to theory, which is just one of many places in contemporary life where we express our infantile struggles. I hope my story can help those of you who are inhibited by your own struggles in this area.

There is a caveat. I will mention a lot of theories in my talk, and give little summaries of what I found in them. Do not believe this account of the work of others. What I am referring to may contain quite distorted, idiosyncratic views of their theories. I am not presenting them to you as carefully reviewed, cited, veridical accounts of what was written or intended. The versions of theory I am presenting here are, rather, what stuck in my mind, for good or ill. Think of them as cartoons or as dream elements. I like to think they bear some relation to the theories, but they are parts of my story, here tonight. Perhaps they are live examples of how we think and tell stories about what we think.

My Intellectual Background

I grew up a wanted, doted-on child, very good in school, from whom a lot was expected. Somehow, with this beginning, I felt I had to fix the troubles that others experienced. I went straight from college to Medical School. I imagined a future role as a charismatic and understanding healer, stimulated by seeing the movie David and Lisa. In this movie, based on Theodore Rubin’s book about Chestnut Lodge, it seemed that very mixed-up kids can, with sensitive, wise understanding, get back on the track to growing up. I wanted to be that sensitive, wise understanding person.

But Medical School is always a detour on the way to a Psychiatric career: for me it included a good deal of empiricism, experiences and cautionary tales about the need to investigate, test, doubt certainties, and not accept authority as correct.

Medical science insists on evidence, and medical theories grow and change at least partly in relation to the accumulation of new evidence, confirming or disconfirming or modifying old beliefs. As Thomas Kuhn pointed out, this is an idealized description of how science proceeds, but it was certainly something I learned and valued.

We do not quite act that way in Psychoanalysis. In the era I grew up in, the schools of analysis barely acknowledged one another. In the current age, they meet and talk and compare, at places such as meetings of the International Psychoanalytic Association. But attempts to cross reference and compare and create one literature, a body of thought that grows by accumulated and revised understandings, the way science does,

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2 He actually found that the old theorists did not adapt to new facts. They had to die out, more or less, and the younger people easily moved on to newer models.
are rare in analysis, and not all that fruitful. We have separate traditions enshrined in separate literatures, each one having its own luminaries, its own name for the thing, and so on.

When I entered residency I was feeling very well educated, but I was unprepared for the tasks of caring for patients. In my discomfort, I was prone to picking up things from my elders, like phrases, mannerisms, ways to dress. At least I could sound like I knew what was going on. One day, on the consult service, I was trying to discourage a referral of an addicted inpatient to our outpatient psychotherapy clinic. Discouraging “dumps” of such patients was a highly valued skill. Referring to addicted, sociopathic patients in therapy, I said “they don’t do well.” The surgical resident told me: if you don’t understand the problem presented by certain patients, and yet you proceed with confidence, indeed they don’t do well. I think I have been reading and trying to profit from experience, ever since, to avoid making judgments about patients’ futures, confounded by what I don’t know.

More background: In my residency I took the family and couples therapy elective, and saw a few couples. The theory I was taught was sort of basic: it was the Mastercharge theory. You draw two circles. This is the husband; this is the wife. The overlap of the circles, the space in the middle of the Mastercharge Logo, was where you were supposed to concentrate your efforts. OK, this was rather minimalist, but I liked it. I was training in Colorado, not the East Coast. Things were simplified there. This allowed me a hook, and a way to proceed. I liked seeing couples, though I might have longed for more explanatory power. But let’s hold onto this little bit of experience, my rudimentary training in couples therapy; it comes back later.

Analytic Training in The Tunnel of Vision

This is a story you may have heard before. It is part of the victim narrative of a certain cohort of analysts, “trained” in an era when there was one analytic theory. Given the medical training we almost all had, there was also a kind of empirical medical bias. So the ego psychological focus on structures and mechanisms was familiar, congenial, and easy to listen to. As Freud had been translated into English, the personified German (the “it”) was turned into the pseudo-scientific English (the “id”). On the background of this training, at my Institute, Melanie Klein’s contribution was downplayed – in class she was referred to as Mrs. Klein, to underscore her lack of a medical degree. The familiar Oedipus Complex was compressed, in her strange scheme (unbelievably, as it was taught), into earlier years than ages 3 to 5, back to infancy, when children could not possibly have thought like that. The whole Freud-Klein controversy was presented as a matter of a reasonable acceptance of the limits of what children could be expected to be able to take in, and a great distrust for leaps of insight based on…. what? …one’s own fantasies? We were taught one theory, and not encouraged to look at alternatives.

Doubt

The first crack in this belief system came with my first control. A. was a brilliant, behaviorally disturbed, seductive and unhappy closeted gay professional man. He came seeking analysis. In addition to his myriad troubles, another reason I wanted to see him in analysis was that, sitting across from me, he looked deep into my eyes, very soulfully, searching for—I didn’t know what. But whatever he wanted, did I have that to give him? Like Freud, I wanted to be out from under my patient’s imploring gaze. Hence the couch. Over 7 years of 5 times a week analysis, we struggled to find a language in which to talk about his troubles, our troubles, our experience together, and what I could do to help him. I always felt he was interested in ME and US as much as in HIM. This made me uncomfortable. I was being taught how to help a person, and here I was part of a troublesome couple. I looked to my supervisor and the literature for a theory of 2-person analysis. At this time the only alternative theory I found close at hand was Kohut’s. Indeed the 2 analyses of Mr. Z kind of made sense; exactly I felt that, like the Kohut of that paper, I was disappointed with this man for not being
more responsive to my attempts at interpretation. Part of the technical approach Kohut was advocating was an emphasis on failures of empathy.

I was not sure about the narcissism part of his theory, but I could surely use the failures of empathy idea. I was always having to apologize for hurting my patient, probably by trying to keep my distance in some way; so, I became interested in failures of empathy.

Kohut’s theory was not a two-person approach. With his notion of selfobjects (one word), it was maybe a one-and-a-half person theory. The selfobject idea was an attempt to explain how the treatment relationship helped such people, while the emphasis on a developmental line of narcissism expanded your view of what might trouble someone, outside of unconscious conflicts between drive and defense. Evelyn Schwaber, the closest thing to a local Kohutian in Boston in the ’70’s, helped. Using what I could gain from her radical focus on listening, I began to be able to listen TO, rather than to listen FOR. I stopped trying to explain the present solely by looking at the past, and concentrated more on painful experiences in the treatment relationship. This made the work go better. But to extrapolate backwards – from the troubles in this control analysis to a theory about the development of this man’s suffering …. That didn’t seem scientifically sound, to me. So my new theory was useful about what not to do, but sort of empty about a deeper understanding.

Don’t Throw that Theory Away; You Might be Able to Use it

Another moment in my candidacy: I was trying to write up my third case, to graduate. This was also a difficult case, a woman with severe anxiety, large holes in her superego, a lot of aggression, and a mistrustful streak. Her father had insisted on inspecting all three sisters, naked, every night after their bath. A psychologist, later he had divorced their mother to marry one of his patients. Surely the overstimulation and Oedipal issues were paramount, and my interpretations would shed light (I began to think, hopefully) on her troubles. Not so much. This was an interesting analysis, and the patient appreciated it very much. But did it work? And to the extent it worked, how did it work?

As I tried to write it up, Paul Myerson, my supervisor, surprised me by suggesting a Kleinian formulation, in terms of envy and the paranoid-schizoid position. I was kind of blown away. We had scoffed at that unscientific stuff, in the 2 classroom sessions devoted to Klein and her followers. And I certainly wasn’t conducting the treatment along Kleinian lines, whatever they might be. But as I thought about it (not one to look a gift horse in the mouth), the fit between her presentation, the intensity of her envy, the primitiveness of her rage and the intense life-and-death struggles she had with sisters and lovers and me -- these seemed well described by resorting to Klein’s intense language. I wrote. I graduated. I filed this moment away.

Learning from Experience: How to Change Direction

About the same time, I was treating a depressed young woman, who was working in business at a very competent level, but had a terrible time with love. She was overweight, but very good at dressing so that she looked stylish, attractive, and alive. She had suffered from a learning disability in childhood. In college she had dated a football player; they were an item, but they never got around to romance or sex. She loved her father, and was disappointed in her mother, but these historical facts were not opening up into anything explanatory.

As I discussed her in my own analysis, I wondered whether I was just not finding the way to get ahold of her Oedipal conflict in a convincing way. My analyst pushed me: what makes you think her problem is a conflict? Well, she didn’t seem to have a narcissistic personality, she wasn’t borderline, so… I thought in terms of conflict, and I didn’t know how to connect her current problems to the themes from her early life. My analyst was unusually talkative that day. Perhaps the learning disability led to a lot of frustration, self-
doubt, pessimism, and that, coupled with her feelings about her weight, and the avoidance of situations in which she might have a better experience, was a plausible story of what she struggled with. The formulation here was entirely in English. It didn’t sound very psychoanalytic to me. Well, I believed in him. I began to listen more open-mindedly to her experience. Soon, things began to happen in the treatment. Then things improved in her personal life.

The treatment was very helpful, ultimately, but as an attempt to use my analytic theories, as I understood them, it was not a success. I had to accept that I might have to stretch what I could listen to, and join with, to be useful.

Later, I found myself seeing a woman whose therapist had begun to suffer from dementia, and abruptly stopped practicing. When I met this woman, she told me about the painful loss of her therapist, and of course some about her personal history. She hated and mistrusted her mother, seemingly from birth. As a grown woman, she would never leave her children with her mother. Her father had been injured in a major automobile accident when she was an adolescent, and from then on he suffered from moderately severe brain damage. He was the only loving parent.

Her husband was a lawyer, who took many trips to The Capitol, clutching a very precious briefcase she was never allowed to touch. They didn’t know much about one another. Perhaps, she mused, he was a spy. Everything in her life was ominous and mysterious. She seemed deeply embedded in the paranoid-schizoid position (you see; I had learned something from Melanie Klein). But I didn’t know what use to make of those words.

As she mourned her therapist, she told me that she knew he had been losing his mind in the last months. She thought he suffered from a physical ailment, as well. She recalled an incident: she told him a dream about an airplane ride. In response, wordlessly, he got up, spread his arms out, and moved around the room like an airplane. Hearing that, I was impressed with the degree of his impairment.

Shortly after this, she was telling me something that puzzled her about our treatment, perhaps why she was not feeling connected to me, and I said, “We can figure it out.” Figure it out? She asked, her voice rising. Figure it out??!! She left the treatment soon after.

On painful reflection, I guessed that the weeks and months of her therapist’s mental impairment, and their closeness as they suffered in the company of each other, had been important and sustaining. Perhaps it recalled her father, the one true supportive object in her early life.

What I am trying to highlight in these stories is how you have to be able to let go of the theory that is not serving, and look around for something else, something different. With my overweight patient, I had the help of my analyst, who pushed me to look further, to relinquish my hold on what I had been trying so hard to get ahold of in training. With the paranoid patient, I was stuck in a too-cognitive mode of thinking or speaking (therapy involving figuring things out); I couldn’t speak to what she was trying to tell me. For her, it was all about what happened between the two people, not what they “learned.”
Thinking, The International Journal, and Me

When I became a supervisor/teacher in the Outpatient Clinic of a Psychiatric hospital, I found myself noting, with my residents, that most of the patients who came to the clinic had difficulties thinking. Not strictly psychotic, they nevertheless routinely had trouble with reality. They couldn’t reliably think about cause and effect. They were full of wishful thinking. They often fudged the reality of finances and time, they seemed to make irrational assessments of risk and reward, and they were inadequately aware of their place in the world, and their effect on others. It made sense that the people who would seek treatment at a Mental Hospital, as opposed to a General Hospital or a mental health clinic, might be a self-selected bunch. But that fact didn’t help me think about how they should be treated. What did I know about non-psychotic disordered thinking?

In my early training, I had learned some of what Freud had to say about thinking. It was closely linked to his model of the mind, a one-person model, where the other’s contribution was to be present or absent, to provide food, to serve as an object of desire, and so forth. Thinking developed out of wishes, frustrated desires. I learned a theory about how the mind was built, with the parents serving as models for the “three I’s”: imitation, incorporation, and identification. I do not do it justice, but this was the structural and drive-theory scaffolding I learned. When I ran into difficulties people had in thinking, in this clinic, these abstract mechanisms did not help me form an idea of what a treater was supposed to do, to help remedy them.

Bion’s work on thinking was a great advance, as far as I could tell. Thinking needed to develop, not just when the desired object was out of reach, but when the child was overwhelmed with something – stimuli, unpleasant affect, and suffering. Building on Melanie Klein’s idea of projective identification, Bion posited that the mother needed to be able to act as a container for her child’s unmetabolized experience: she could take it inside herself, think, dream, feel and process it, and return it as communications that made sense of it, made it more manageable. That container-contained relation is what led to the development of thinking in the child. And the function of thinking is to manage, process, and learn from experience. I couldn’t understand what he wrote, the first 2 or 3 times I read Bion, and I may have made a hash of it here. But had I taken it in, it would have provided a way to understand how a therapist in my clinic, or an analyst, might help a patient transform unpleasant experience into thought, and deal more directly with his troubling reality.

Remember my couple therapy training? As a supervisor, I was good at listening to the couple that the resident brought to me, the patient and therapist couple, and explicating what was going on. There was a lot of Schwaber here, at least as I used her, and a good bit of Robert Langs – how the resident-therapist was not hearing what the patient was saying. How one (a supervisor, say) could hear the patient commenting on the therapist’s unhelpful interventions. Added to my increasingly strong conviction that thinking was a problem for these outpatients, I felt I had a practical approach that sort of worked. But worked how? Worked to do what? It worked to contain anxiety in the therapist, for sure. Hearing the therapy as a two-person system, I could make sense of what was going on, and contain the resident’s anxiety. The resident was then better able to contain his or her patient’s anxiety, in the subsequent sessions. I still wanted an explanatory theory.

Meanwhile, I was reading the International Journal, which I loved; reading it was like travelling to foreign places, where the culture and assumptions were different. I didn’t see how to apply those theories to these patients, at first. The papers in the International Journal had a charming insistence on theory, on an unconscious, a structured unconscious. I was working with Kohutian/Schwaberian techniques, but dissatisfied with what I felt was a relative neglect of the unconscious. If the job of psychoanalyst was a more humble one than I had hoped, and above all required careful listening to what the patient intended to say, where was the Freudian greatness in that? No conquistadors need apply. It was, well, it was a lot like being a good mother!
No brilliant interpretations were needed. Listen and stay out of the way. I was not personally satisfied with that, however useful it was.

My search for a real muscular psychoanalytic theory was gratified when I began to take in the contemporary Kleinians, Bion, the Bionians, and the contemporary Italians. Many years later, I feel I can get something more than esthetic pleasure from these theories, and relate them to my work with my particular crop of challenging patients.

At the time I am speaking of, though, when I was teaching in the Clinic, there was a problem with my acceptance of the interesting and deep theories in the International Journal. I loved the depth psychology, but I was always put off by the apodictic and charismatic aspects of the traditions. The words “Bion says this” or “Tustin described this” seemed to begin and end the literature review of many papers. The intensity, tightness, and cohesiveness of the schools of thought bugged me. I was already dissatisfied by my own school, but as a medical empiricist, and an American (more or less) pragmatist, schools and argument by authority made me uneasy.

Immersion

After graduation, I managed to find myself with a full psychotherapy practice, including 5 patients who engaged in analysis. This was very gratifying, since the work was deep and fascinating, and fed my hopes for professional advancement, as well. But more than that, it taught me what I didn’t understand, but could investigate and engage with.

When I was qualifying as a training analyst, with my last interviewer, I presented a professional woman of some accomplishment, whose mother was a severely traumatized woman. This patient, referred to me by her couple therapist, had done a first analysis with a training analyst, and had been turned down by her therapist for a second analysis. She had also been turned down as a supervised case, because she had a “psychosomatic disease.” In the first few days after beginning our treatment, she came in with excitement and announced, I can dream again. She readily moved to analysis, 4 times a week, and this went well, but she soon discovered that she did not like using the couch.

This is an understatement. On the couch, she felt she lost me, I lost her, and she drifted into unpleasant states, bordering on panic. We together surmised that this had something to do with her mother, and their early attachment (or, really, the difficulty in that attachment). The problem persisted. It wasn’t really that severe a problem, because she sat up most of the time. But I guess it was a problem for me, since I needed to be doing analysis, and we at BPSI, in North American Psychoanalysis, didn’t call 4-times-a-week face to face treatment, analysis. When I presented this case to my interviewer, it did not go well. I remember (this account may be full of self-justifying distortion, and my interviewer is no longer here to tell the story her way) more or less engaging in an argument. The interviewer was clear that I was not ‘keeping her feet to the fire,’ not getting her to use the couch and face the anxiety. My view was that the patient felt she lost me in those times, and had me available to her in the face-to-face sessions, and that was what she needed. I argued for the patient’s strength, her essential capacity to make use of the treatment, a kind of real (as opposed to theoretical) definition of analyzability.

This interview was not a very successful meeting of the minds. Subsequently, I saw a very learned and humane supervisor. But we clashed over the same issue. He told me my patient’s not using the couch was like playing tennis without a net. It was not tennis—it was not analysis. He may have been right in a sense. But I thought it was the analysis she and I could do, usefully; maybe I needed a definition of analysis that encompassed the things that worked, for the patients I actually met, rather than an idea derived from a theory
we had been given, that described only a limited number of kinds of patients and a limited number of kinds of analytic processes.

Now neither the interviewer, nor the supervisor, suggested a theory that might explicate the analysis we were doing, and the troubling states my patient continued to have. Perhaps I needed Andre Green’s dead mother, Tustin’s autistic states, or the ways the Kleinians like Betty Joseph dealt with patients who were hard to reach. It was hard to reach one another, when she was lying down, but easy to do so, face-to-face. It could have been interesting.

Looking at the case from years later, I can see some other possibilities. She complained that I did not sound the same to her, when she was on the couch, in these states, as I did when she was sitting up, face to face. I remember, I was aware that my voice sounded flat, to me, at those times. Now, I wonder, what was going on inside me? While my patient was slipping into a state of impaired relatedness, so was I. What was up with that? Starting from my own experience, adding it to hers, perhaps there was a way to proceed towards a deepened understanding of her states, and mine. But I would have had to look more carefully at mine. It would have helped to have more theory, or deeper supervision, or to have confronted those states in my own analysis (I did not). Maybe I needed an experience that was more disturbing, an eruption from a troubled part of my unconscious. If I was having dreams that were speaking about these aspects of my psyche, I could not hear the message.

What’s My Theory?

When psychoanalysis gave up the idea that there was only one theory, it became important, in psychoanalysis, to label oneself – to locate oneself on the theory spectrum. I was asked to discuss a paper by a famous relational analyst who was coming to town. I was asked, what sort of analyst was I? I chose to describe myself as a Recovering Ego Psychologist. It is hard to pin down what about ego psychology I find problematic, and what I take for granted, and continue to use and rely on. I surely had a problem with the received wisdom about analyzability. This was (and I probably had this wrong) the basic message of focusing on the ego: assessing what the patient could stand, what he was capable of.

Too often, this sounded like how to avoid the difficult patients. But my work at McLean Hospital delivered these people to my office, and I had some success with them, in non-analytic treatments. I couldn’t (and didn’t want to) avoid the difficult patients. So I learned a lot. I learned that some were too difficult (for me), some needed something less withholding than “classical” analysis, and for some an analytic process could take place. Though I wrote about the borderline diagnosis, my natural inclinations were to be wary of such diagnoses, such simplifications of a human being. I was much more interested in whether a process could be established, and how, and what kind of process it was, and what changes might result.

Teaching was also helpful. I remember a period when I flirted with Lacan’s theories. I read some of him, read some of the explications designed to make his work accessible. I would explore these ideas in my case conferences, in the outpatient department. What was interesting was this: trying to link up my rudimentary understanding of Lacan’s unique and difficult theories, with the work of my students, and my own (unarticulated) clinical theories, was more fruitful than I had reason to hope it would be. For example, I was impressed by Lacan’s notion of the inscription, the story of who this child will become, inscribed linguistically from birth and before, often in the choice of a name. I remember introducing that idea, in discussing a new case in the case conference I taught, and noticing that, often, it led to a very satisfactory discussion. It got us

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closer to the power of the unconscious, and richer ideas and observations emerged. I couldn’t become a Lacanian, for sure, but I could appreciate there was power in the ideas. Now this is the same time, more or less, that I learned (from my supervisor) that I could apply, retrospectively, a Kleinian theory to an analysis conducted in Boston by a candidate with no real knowledge of Klein’s essential contribution. I came to think that most theories in psychoanalysis, when applied to clinical material, provide interesting and useful ideas.

One thing I am saying, is that theories, even arcane and troublesome ones like Lacan’s, even ones that seem to violate common sense, like Klein’s, or that are devilishly hard to follow, like Bion’s or Matte-Blanco’s, or Andre Green’s, have some great power to help us think about clinical processes. Maybe they provide a temporary scaffolding, in the consulting room, as well as out of it, to help us move more deeply into what we are struggling with.

I Hate Broccoli

I gradually moved from being a young person, in opposition to authority, to being an authority of sorts, myself. Soon enough, I began to learn about the dangers inherent in that development.

Shortly after I became a training and supervising analyst, I was asked to serve on a Committee at the American Psychoanalytic Association. The job was to evaluate the applications of younger, ambitious analysts (like I had been) to qualify for further advancement. The committee toiled over case reports that had been submitted to the committee by these young analysts. Most of the reports told the story of cases they had treated during their training.

I read a few applications from young people influenced by Paul Gray, the great ego psychologist. Paul Gray’s particular contribution to Ego Psychology was a method of close listening which involved calling to the patient’s attention moments when he or she paused, when the stream of talk (associations) ran into some kind of micro road-block. By pointing out the hesitation, the resistance to saying the next thing that came to mind, he could encourage the patient to consider the way his (the patient’s) own mind worked, as well as what he was avoiding at that moment.

When Dr. Gray came to do a workshop in Boston, I asked him, where was the place of counter-transference in his thinking. Dr. Gray replied calmly, with my method, there is no counter-transference. (Ha! I thought. No wonder I am so provoked and dissatisfied by his writings).

Working with this committee, then, I got a chance to come into contact with Dr. Gray’s influence on his students. Over the course of three cases, a reader could see the young analyst’s development. An applicant would report that, at a certain point, he had asked Dr. Gray to supervise this case, and I could follow with consternation the shift in emphasis in the work. The analyst turned away from exploring feelings, transference, counter-transference, the influence of the past on the present, Oedipal passions, deep longings and passionate engagement. He stopped making interpretations. He began to focus on these minute moments of resistance. The young analyst might take on a next case, and his work (or his reports of his work) would now continue in this narrow, cramped style. I groaned to myself (Well, mostly I groaned to myself. I was a member of a committee. Sometimes I groaned out loud). I bemoaned the fact that a pliable young mind and soul had been, if not exactly snuffed out, it had shrunk, turned gray, been rendered obsessive and somehow miniaturized. The only disturbance to my enjoyment and horror at reading about this was that the patients seemed to do quite well. The work seemed to progress, the patients got better, they developed strong feelings for the analyst, and good things happened in their lives. Hmmmm. Maybe there is not just one way to do analysis. Maybe my objection to this approach was on esthetic grounds, or a personal preference, or a wish.
The “Something Else” and the Earthquake of 1989

In 1989, on October 17th, just before the start of the 3d game of the World Series between two San Francisco Bay baseball teams, there was an earthquake (the Loma Prieta quake, 7.2 on the Richter Scale). For some days, transportation was massively disrupted, as was communication. People could not get to their analytic sessions! Even more unusually, analysts did not know whether their patients were OK. Some months later, a report of the San Francisco analysts’ experiences was included in an edition of TAP, the newsletter of the American Psychoanalytic Association.

In this article, the analysts reported their consternation, confusion and distress about not hearing from their patients. Concerns that they were killed, or seriously injured, and so forth, were prominent. You could feel the distress of the analysts in their reports. What I was struck by, and want to highlight here, was an impression that these analysts were surprised at how much they missed, and worried about, their patients. I noticed how odd that seemed to me, that they did not take for granted that these people, with whom they met frequently, talked searchingly, struggled, people who they supported and confronted, and whose lives and hopes and fantasies they shared, mattered so much to them. It seemed to me the theory that we were all working with, that the basic treatment relationship is dominated by transference, avoided a different, basic fact – that these are real, important, relationships, happening in real time, between two people.

It occurs to me I have brought up an earthquake. Perhaps part of why the earthquake was so revealing, to these analysts, was that earthquakes are uncanny experiences, very unsettling by their nature. If the earth is not solid beneath our feet, what IS solid? Surely not theory. Surely not a particular way of categorizing something. Another thing about earthquakes is that they happen because of a fault line. Perhaps, if there is a fault line between two different ways of thinking about what happens in treatment, it may take a kind of earthquake to get unsettled enough to look at one’s experience in a different way.

The paradox of theory’s usefulness is evident to us. If we have no theory to guide us, we are lost. As my surgery professor’s wall plaque said: You only see what you look for; you only look for what you know. But if you only see what you know, how do you see the things you don’t yet know? How does the field grow? The way forward can be specified in a scientific discipline, where you might search for more understanding of something you don’t understand, but can describe, operationalize, and experiment with. But in our field? Perhaps you have to be puzzled, caught in some enactment or repetition or stalemate, and then become disturbed enough to allow yourself to be surprised and upset into a new look. Or, you might find a new idea, at least new to you, in the literature. It is almost always true that, when you read a new paper, you are awakened to new possibilities in your consulting room, or someone else’s, very soon thereafter.

I think an important feature about theories, or the way we use them, is whether they close down or open up. They should open up.

The theories that we rely on, as we try to clarify, illuminate, and explain what is going in treatments, can be very useful. They can ground us. But they don’t really encompass what is going on. As the French say, theory is a very good thing, but it doesn’t prevent something from existing. Theories are not only provisional; they are necessarily one-sided, and incomplete. They often come along to challenge the old theories that have been failing us in certain ways. The new ones have not yet failed; but if we give them time, they will, too.
A Final Note about the State of Analytic Theory Today

In the last two or three decades, there have been significant changes in the intellectual culture of psychoanalysis. There is no longer one “theory” staving off a succession of heresies that need to be debunked. In the US there is a tradition of ego psychology, but there are also self-psychology and relational analysis, numerous approaches that privilege the two-person nature of the analytic experience, the cure and the pathology. In England, the British Society, having withstood the Freud-Klein controversies, settled into a practice of encompassing three different groups, and traditions, and theories, coexisting in a very fruitful mix. In Europe, Klein’s influence was great, but also Winnicott’s. And the French had a variety of innovative theorists, Lacan being the most original, but many establishing their own intricate lines of inquiry. The psychosomatic school, particularly, addressed a whole area of experience that got shut down on this side of the ocean, when the over-reaching of American Psychosomatic speculation ran into the cold pragmatism of medical and physiological science.

The South Americans took in theory from Europe, not North America. Perhaps because they were host to many escaped Nazis, as well as many escaped analysts, Argentina and Brazil responded warmly to Klein’s views of primitive mental function, projective identification, and the importance of aggression. They taught these ideas very devotedly, but also spawned a more creative and encompassing view of psychoanalytic experience, for example in the Barangers’ Field Theory.

Taking in the world-wide scope of analytic thought, it seems to me the “standard” theory, the lingua franca of the field, is Kleinian more than ego-psychological. The focus of current interest in the field is not on the “classically neurotic patient” that I was taught to seek, but various kinds of primitive mental function, or unformulated experience.

It is a very rich stew of ideas, incompletely compared and collated. There may still be a pressure to choose, learn one theory well, and treat the others as curiosities; but that approach won’t fit the reality.

You couldn’t get the drift of all of this by reading North American journals, at least not until very recently. You needed the International Journal.

Summary and Afterthought

As I said at the beginning of this paper, I have been up to a few different things here. I have told you a version of my analytic journey of discovery – how I learned to do whatever I do and teach. I gave you some notion of the habits of mind I started with, a kind of medical/American pragmatism, and a not-so-hidden belief that relating has something to do with it, too.

I referred to many aspects of my clinical experience, as a resident, a Psychiatrist in a Mental Hospital, a teacher in an outpatient clinic, a psychoanalytic candidate, and a therapist-analyst practitioner. In each role, I was disappointed with my limitations and the limitations of my approach, and occasionally learned something essential about what patients bring to their treatments, what they need help with, and what kinds of engagement work.

Along the way, I have tried to remain open to the theory I was being taught, the theory I read, and the implicit theories I wasn’t being taught, but found myself using, and ultimately teaching. I have been trying to discuss and demonstrate what it might mean to keep an open mind, with the very flawed mind we are stuck with, the one that is always looking for a way to close itself. Theory is there to help us open that mind up, but mostly we tend not to use it that way for long. Disruptions like mini-earthquakes occur a lot in this kind of work, and they are essential to opening us up to what we are in, and not seeing. If there is a central payoff to
what I have learned over this journey, so far, perhaps it is in my becoming freer to think and say what is on my mind, in the moment, in the room.

In the middle of this story, you remember, I began to describe myself as a recovering ego psychologist. What I think I was trying to recover from was a constricted notion of how these treatments work, who can respond to them, and what the data are. I don’t want to sound like I have the answers. The whole point of this communication, for me, is to remember to pay more attention to what I don’t know, than to what I think I know. Not knowing is essential, so I can be somewhere, in the new situation, with this patient. It’s more about being, than about knowing, and it’s more about what is happening now, than what happened in the past.