PSYCHOANALYSIS: NO NEW DAWN

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RH: YOU HAVE SOME PSYCHOANALYTIC BACKGROUND, DON'T YOU? EDUCATIONAL AND THERAPEUTIC?

RBL: Both. My residency training was psychoanalytically oriented, and I also obtained further psychoanalytic training later. In addition, I have been in psychoanalysis twice as a patient--once for a period of about five years and then for two more years with a different analyst, after my first analyst had left town.

RH: WERE YOUR ANALYSES HELPFUL TO YOU?

RBL: I think they were, but I have some doubts. I cannot really point out how they were helpful, except that I became more self-observant and began to work out some issues about my father. On the other hand, my analyses never reached deeply into me--into the core of my being. I remember, I cried a few times over the years, but I don't remember having had deeply involving, heart-rending human experiences of the kind that our patients have regularly. It was essentially a long process of serious and very thoughtful cognitive wonderings, and as such it was helpful, I assume. I do not think that there were major shifts in my personality as a result of the analyses. Those shifts came later.

RH: PERSONALLY, PSYCHOANALYSIS HAS FOR A LONG TIME CONJURED UP IN ME A SENSE OF MYSTERY, LIKE PROBING FOR UNKNOWN SECRETS. AND IT ALWAYS HAS HAD A "CHARGE" TO IT. TALKING ABOUT A "NEW DAWN" OF PSYCHOANALYSIS ALSO SOUNDS ROMANTIC, LIKE A MYSTERY.

RBL: You are making a good point. Indeed, speaking of a "New Dawn" conjures up romantic images. In literary movements we think in terms of cyclic trends, as we do in painting or in poetry, for instance, we go from abstract expressions back to realism, from the free-flow of ideas to very disciplined and formal forms of writing, from classic to romantic, from

programmed to non-programmed music. Throughout history there have been ups and downs in such movements. But psychoanalysis should rightly not be grouped with such phenomena, and it ought not be subject to swings in style. It claims to be a scientific system within medicine useful in treating illness. The great promise of psychoanalysis in the 40's and 50's was followed by disappointment and decline, so understandably some may wish for a "new dawn". But, I believe, evoking such romantic imagery in itself suggests what is wrong with it.

Only to its devotees and "true" believers, psychoanalysis is a mystery-filled form of human expression and human creativity. Psychoanalytic theory is a brilliant attempt to explain human behavior and motivations, correct in parts, incorrect in others. But, it has a very specific purpose, that of curing certain illnesses. It ought, therefore, fit not with the imagery of a "new dawn" after the long night of decline. We need to recognize again the usefulness of many parts of its theory, but it behooves us as psychotherapists to beware of the romantic wish to revive something which should not be revived because it is no longer valid. We are not ever likely to treat tuberculosis again the way we used to, by sending people to breathe fresh air in the Alps. We now have better ways to treat it, and the old ways, pleasant as they were, are not likely to ever be revived. Medicine doesn't go back to old treatments when better ones exist. As a method of treatment for mental and emotional illnesses psychoanalysis was never very successful or very effective, although it used to be the best we had.

We and the patients have every reason to expect that what was done 30, 40 or 50 years ago should be done much, much better now. Psychoanalysis has changed in many ways, but not in its essential approaches. It is a fascinating exercise in cognitive exploration of the self but,

unfortunately, is handicapped at the outset by not involving patients intensely enough in the curative process. It fails to cure the illnesses with which patients come to us. As a curative process it has been bankrupt all along, because there are some serious and basic flaws in its theory and in technique. Freud's brilliant contributions about unconscious motivation and overdetermined behavior should not blind us with their brilliance to the glaring misconceptions which have misled us.

RH: BUT, THERE HAVE BEEN REVISIONS IN PSYCHOANALYTIC THEORY SINCE, BY HARTMANN, KOHUT AND KERNBERG AND IN TECHNIQUE BY ROSEN, SEARLES AND SPOTNITZ, AND BY OTHERS.

RBL: Well, not really, not relating to the basic flaws. There have been modifications in the theory, but they do not question such issues as the centrality of the oedipal conflict and the fear of castration as a means of resolving the oedipal wishes. Do you think it makes sense in the age of Garp to hold on to "vagina dentata" as symbolism? And they all assume, more or less, that interpretations, clarifications and reconstructions actually heal. I believe these are all wrong.

RH: WHAT ABOUT THE KLEINIANS?

RBL: It is true that the Kleinians recognize the earlier determinants of personality formation, and as such they are more correct than the classical Freudians. It is also true that we do not know what really happens in the privacy of a consulting room, and many analysts may have introduced aspects of treatment that change the practice much more than the published reports. Nonetheless, the essential element of the psychoanalytic process is free association, the analyst remains relatively anonymous in the background, uninvolved, making reconstructions and interpretations. That has remained essentially unchanged. Some analysts are warmer and at least greet the patient openly, but many more claim (wrongly, in my opinion) that the principles of psychoanalysis demand that they stay aloof. It remains essentially a process in which the cognitive

processes of the patient are addressed by the cognitive processes of the analyst, and the interchange between them is essentially merely an intellectual, not a human, one. Obviously, this is not always true. Thoughtful analysts know that working-through does not just mean increased understanding, that one really has to have corrective experiences. But, the method condemns the process. Almost invariably it achieves no more than greater understanding.

This is really the central premise by which psychoanalysis tries to achieve its goals, which are often not even claimed as trying to effect cures. Everyone knows that cognitive understanding is not enough and that emotional or affective insight is necessary. But in practice most of classical Freudian psychoanalysis involves increasing the scope of cognitive understanding. The assumption is that as we increase knowledge we increase power, and that if we only <u>know</u> our unconscious, surely we will be in control of it. These are remnants of 19th Century rationalism, when Man deluded himself to believe that he is a rational being. Freud theorized otherwise, but neither he nor his followers practiced as if these theories were true. This is accepting nonsense as sense. Clinically, it has been proven again and again not to be valid, and I believe that the clinical results of psychoanalysis are consequently very poor. Many, many people who have gone through psychoanalytic treatment have become, as I have become, much wiser to themselves, to the process, to how people work and to how people are. But, the <u>real</u> changes in the personality which are determined and fixed as the earliest determinants in life, these need other and greater forces to bear upon them. Much more powerful interventions are required, and the real relationship has to be much more intense than that provided for in psychoanalysis. These are some of the faults that caused psychoanalysis to decline and to not remain a central form of treatment in psychiatry. Many new

approaches, both valid and invalid, have been promoted because this, the most promising of all approaches, came to the night of its decline. I do not see any "dawn" or re-birth on the horizon, except as a wish by those who are emotionally caught by its aura, by its promise or by its romance.

RH: IT'S TRUE THAT IN PSYCHOANALYSIS, ACROSS THE BOARD, EVEN WITH THE KLEINIANS, THE BASIC ENCOUNTER IS THROUGH INTERPRETATION, FROM INTELLECT TO INTELLECT, BY AND LARGE.

RBL: Yes, and that is why I do not differentiate between the Kleinians, the Jungians and the Freudians. In this sense there is essentially little difference, although they, obviously, differ greatly otherwise. I think we can, therefore, consider for this discussion the various approaches as one. Some of these approaches may be more valid than others, but the different psychoanalytic schools are all similar in this basic sense.

RH: CLASSICAL PSYCHOANALYTIC THEORY MAKES ROOM AND ENCOURAGES A TRANS-- FERENCE TO GROW--CREATES CONDITIONS FOR THE TRANSFERENCE TO GROW--AND THE WORK OCCURS WITHIN THE TRANSFERENCE. YOU ALSO WORK WITH TRANSFERENCES. IN THAT ASPECT YOU DON'T DIFFER FROM IT.

RBL: Not true. Even there I differ, because I believe that when an analyst remains neutral and anonymous as a human being and when his human qualities cannot be ascertained and tested by the patient, then the transferences cannot really develop as intensely as they should. In these situations there is not enough of a real relationship with the analyst for patients to know, beyond cognition, that the relationship is a safe one. If the patients cannot experience the human stability and dependability of the analyst as a person, then they cannot and should not let themselves go beyond a certain point. That is unless they are psychotic or unless they have blind trust in the analyst based on being "true believers" in psychoanalysis. Dynamically, it's the same as the Guyana people's trust in Jim Jones.

RH: BECAUSE THEY HAVE TO BE CAUTIOUS FROM WITHIN...?

RBL: ...because the basic transference is that of the child toward a parenting figure. Each of us, every person, has been on very shaky ground in our earliest moments and days of life, because we were completely powerless. We all must have experienced our existence at that time, when we were totally unable to comprehend anything of what was occurring to us, as directly and literally life threatening. We were all exposed to harsh lights, to loud sounds, or we were held not firmly or securely enough. These early life experiences must have caused tremendous anxiety, panic in fact, parts of which re-emerge later in life as free-floating anxiety. To ward off such panic early in life we develop a rich variety of personality characteristics and symptoms. In the analytic setting, that anxiety is re-awakened through the transference toward the analyst. If the analyst is not known as a real person, who is very much there in his humanity even if his biographical and statistical details remain unknown, then the patient cannot but relate to the analyst as a very young and small infant does to a big and overwhelming parent, in a pleasing and self-effacing attitude. Such a patient would have to please and would never dare challenge. Patients, as you know, always try to discern what the hidden wishes of the powerful figure of analyst or psychotherapist are, and unless they experience true safety, they make no waves. Although this may be somewhat exaggerated, I believe that this is basically what happens in analysis. What must be done, instead, is to develop a strong and real relationship, against whose background all the transference distortions can be examined and worked with. Each of us has experienced pre-verbal hunger and yearnings as well as pre-verbal rage. Early in infancy we all had no choice but sometimes to fold-in in order to survive, and such feelings had to be relegated to the realm of the unconscious, because it

seemed unsafe otherwise. In psychoanalysis a real relationship cannot develop sufficiently, and it can't become a powerful enough force because of how the setting is constructed. Patients remain stuck in the basic transference, and other transferences cannot really fully develop. So we have, in essence, a repetition in the present of the pathological adjustments of early infancy. The approach to the patient must be quite different. The real relationship must prove reliable enough so that patients find room in it to experience the negative transference towards us with full force. They must work it out with us, in relation to us, express in our direction all the fury before the depression lifts.

RH: COGNITIVE, INTELLECTUALIZED CONTACTS OBVIOUSLY DO NOT GO DEEP ENOUGH INTO THE PERSON TO MAKE A FUNDAMENTAL CHANGE, I.E. A PRE-INTELLECTUAL CHANGE, A PHYSIOLOGICAL CHANGE.

RBL: That's right. Depression which is the universal, underlying illness of all psychiatric disorders is not an illness of cognition or of understanding. Otherwise, all we would have to do is learn about our being, about ourselves. But this has proven to be ineffective in truly lifting the depression. There has to be a reversal of the physiologic adaptations that a person develops very, very, early in life.

RH: THE PRE-COGNITIVE EXPERIENCE MUST ALSO PROVIDE THE FOUNDATION FOR THE DEVELOPING INTELLECT AND COGNITION. SO, THE PRE-COGNITIVE DISTORTIONS MUST ALSO GIVE RISE TO DISTORTIONS IN COGNITION. ANYTHING THAT IS ADDRESSED TO THE COGNITION HAS DISTORTIONS BUILT INTO IT FROM AN EARLIER TIME. THAT'S WHAT NECESSITATES THE WORK WITH THE "BUILDING BLOCKS".

RBL: Exactly. Real work of personality change cannot be done through the medium of cognition alone since it is already involved in the distortion of perception. As you know from our work with patients, even when they finally have physiologically, affectively and cognitively worked-through much of the early panic and rage, issues that are underneath all the presenting symptoms, it is still very difficult for them to change their old habits

of existence. Even then, it is often necessary to push the patients repeatedly, if they are to change their mode of existence. Even when the issues become conflict-free, the habits of existence remain. So, even working it through physiologically, affectively and cognitively may still not be enough. Psychoanalysis at best is successful in working some issues through cognitively, and many areas are not addressed properly and forever remain conflictual. If the affective charge has not been drained, it is naive to assume that real personality change can be effected. Symptoms may be modified, and they often are. But, what psychoanalysts recognize correctly about symptom substitution in behavioral approaches may paradoxically and sadly also apply to their own clinical results.

RH: YOU WOULD ADDRESS EARLIER PHASES OF DEVELOPMENT THAN THOSE THAT CAN BE REMEMBERED AND CONSIDERED INTELLECTUALLY.

RBL That's right. If the oedipal conflict is central, then it makes good sense to talk cognitively and try to understand those issues. What happened at age 3, 4 or 5 years is too late. We are more interested in what happened at age 3, 4 or 5 hours, days or months.

RH: SO THE INTENSITY OF THE INTERVENTION NEEDS TO BE GREATER?

RBL: No, the direction of the intervention has to be focused elsewhere. What generally happens in psychoanalysis is content-oriented, because of the way it postulates the etiology and pathogenesis of these conditions. The right approach would be process-oriented, because we contend that the pathology originates from a time when content as such was meaningless. The important pathologic character adjustments were established and fixed long before memory and meaning existed for the infant.

RH: I KNOW THAT YOU CONSTANTLY SCAN THE PATIENT'S PHYSIOLOGY--WHAT SHOWS IN THE EYES, THE TURGOR OF THE SKIN...?

RBL: Yes, how the patient sits, or lies, how he tells us his or her story even more than what he tells us. Let me give you a simple-minded example. A patient

may come in for an initial interview, and I would ask him, "Well, what's wrong with you?" And, he might say, "My wife divorced me, and ever since I can't sleep at night." I'd say, "That's bad, but how do you feel now?" And he would say, "Fine." And I might say, "But, you look so pale," or "you hardly breathe. Will you sit forward please and take a deep breath." Although I do not ignore the presenting complaint, it can only be meaningfully addressed in the context of a real relationship. At that moment that man hardly takes a breath. He is, obviously, right then and there frozen in panic, even if he somehow managed to find my office. Process comes before content, what I observe takes precedence over what he tells me. The physiology is a more honest witness than the words. It never lies, the mouth often does.

Or, if the new patient comes late I would always address that at length, even though he or she probably has another, seemingly more important, agenda. The patient would offer some rationalizations, and I would say, "Yes, that's possible. But, could it be that you had some mixed feelings about being here? Could it be that you are scared?" He might reply, "Why would I be scared? You come highly recommended, you are a physician, you have a good reputation. Why should I be scared?" Again, I would respond to the way he <u>is</u>, not to what he says, discounting the rationalization: "I don't know why you should be scared, but <u>are</u> you?" He might not "know", having always denied his feelings, but it usually is easy to demonstrate that he is experiencing with me feelings that are similar to those experienced when he was abandoned by his wife. Rather than talk <u>about</u> it, I bring it right into the here and now of our relationship, and I make real contact with him there and then. The panic about the wife eventually gets addressed, but mostly as it is reflected back from what had just happened between us. This is altogether different than my asking him how long he was married, or what precipitated the break-down of their relationship or whether or not he still loves his wife. When we work in a correct

theoretical model we need to gather information less and we can make meaningful contact from the very outset.

I have attended conferences where therapists reported that for six months or even for a year they essentially gathered information. This was justified by the naive belief that if we only find out the mysterious secrets of unconscious motives and make the unconscious conscious, a cure will be effected. But, this is simply not true. It's a myth hallowed by Freud's early writings that many still hold on to blindly. Things do not work this way.

There are many shadings to psychoanalysis, but in general, it is content-oriented. And, I believe that clinical observations prove beyond doubt that from the very beginning the approach must be altogether different. A patient may tell me, "My father beat me when I was a little boy," or, "My mother was harsh when I was toilet trained." But, these are not the real issues. Almost everything was already determined by the time we have conscious memories.

RH: CERTAINLY EVEN A PATIENT'S REPORT IS DETERMINED BY THE PRE-VERBAL DISTORTIONS.

RBL: Exactly, His report, his memory, his non-memory. What one chooses to speculate upon in the absence of memories. These are all tainted by pre-verbal distortions. The patient tells us what he unconsciously believes will be helpful in curing him. Most people who come to psychoanalysis do not come blind, off the street. They usually belong to a small, elite group that knows intellectually what psychoanalysis is, and they give us the material they think we want to hear. But, I do not want to hear it, I want to know, instead, why he is so pale. And he says, "Well, now, wait a second. I didn't come here to talk to you about my lateness or my paleness. I came here because I have this difficulty with my wife." Nonetheless, in spite of the protest, below the conscious level, he senses my real contact with him as I address how he is at that moment, rather than what he thinks.

RH: I JUST HAD A THOUGHT. I WAS WONDERING WHILE WE WERE TALKING WHY THERE IS SUCH AN OVER-INVESTMENT IN THE INTELLECT BY WELL-MEANING, HONEST PRACTITIONERS AS WELL AS BY SO MANY PATIENTS? THE INTELLECT ITSELF MUST HAVE TRANSFERENTIAL MEANINGS TO THE PERSON, FROM EARLIER STATES OF BEING WHEN ONE WAS POWERLESS AND HAD NO CONTROL OVER HIS ENVIRONMENT. THE DEVELOPING INTELLECT PROVIDES THE INFANT WITH SOME SENSE OF POWER AND CONTROL, AND SO WE INVEST IT WITH A "CARE-TAKER" KIND OF TRANSFERENCE.

RBL: I think that is a very valid and astute observation. In the 19th Century view of rationalism, we assumed that knowledge is power, and this is true in the sense that knowledge helped Man conquer the forces of nature. Nature then helped us, rather than threatened us. But, as you say very correctly, it goes beyond that. It is true that powerless newborn infants gain a sense or delusion of having power by gaining cognition. We soon "learn" that if we behave in certain modes of behavior it is more likely that Mother will come to feed or hold us. So, as we gain cognition and knowledge, we gain some real power to manipulate the environment, real help in survival. This may be at the root of why Western Man has ascribed so much mystical power to Knowledge, beyond the power that knowledge really has.

I can know very, very well, for instance, that I have pneumonia, and as a physician I can even understand in detail its pathogenesis, what is actually happening in my sick lungs. But that knowledge has absolutely no relevance to whether or not I will die of this pneumonia, or whether I will get well. What alters the pathologic conditions are specific interventions by modern Medicine, on the one hand, and what is culturally spoken of as the "will to live", on the other. It does matter whether or not I consciously and unconsciously wish to succumb to an illness. These two are real forces, but whether I understand, or don't understand, is irrelevant.

What we must do is to engage the body, the patient's physiology, not just his brain. This can best be achieved by verbal stimuli that involve the patient's subjective symbolic meanings of phenomena, and to a lesser extent through direct work with the body, such as Radix, Bio-Energetics or the scream therapies. We would not use these routinely, and they cannot do the job when

used exclusively, but they can be very helpful. Unlike antibiotics for pneumonia, drugs in our field only lower the panic for a while, but they do not treat the illness.

True change can only occur after the physiology is repeatedly engaged with sufficient intensity. It takes so much time because the force that propels the phenomenon of repetition-compulsion is so powerful. The self-defeating and self-destructive tendencies repeat themselves forever unless their unconscious reasons for being are worked-through enough in one's whole being. All this to me seems so self-evident. We are not trying to manipulate the body, nor can we magically reverse life-long physiologic patterns. But, we must give up our mystical belief that understanding cures. Understanding does not cure.

We are different than our early ancestors and different from other creatures in the animal kingdom because of the size of our brain. It has allowed us to achieve so much in the universe, and it was helpful to each of us in lowering our anxiety ever since the earliest days of life. It is understandable, therefore, that we adore that brain, that it became the idol of modern Man, and that we sort of worship it. This is how "the cure" is usually portrayed on T.V.: The patient finally understands some hidden fact from his unconscious and well-being soon follows. Long live the Brain! It seems only natural, therefore, to also assume that if we only developed our brain, we would surely be saved. How many times have you heard educated, sophisticated, people say, "Well, I don't understand, such a very bright man (or woman), why is he so sick? Why did he do it?" It follows that some psychotherapists actually recommend in all seriousness that patients sit back, meditate and think about who has hurt them, who they are angry at, or how they might love themselves more, as if such thinking would or could make a real difference.

RH: THE INFANT'S EXPERIENCE OF FOLDING-IN OR OF GIVING-UP MUST ALSO DETERMINE HOW HE OR SHE EXPERIENCES THE ORAL, ANAL, AND, IN FACT, ALL THE PHASES OF DEVELOPMENT. IT MUST BE OF CENTRAL IMPORTANCE IN DETERMINING PRODUCTIVITY, RETREAT OR NON-RETREAT FROM REALITY, OR GUILT, AND HOW THE OEDIPAL CONFLICT IS EXPERIENCED. SO THEORETICALLY, THIS MUST BE ADDRESSED FIRST.

RBL: It must be addressed first, second and third, all of the time. When one is folded-in, outside stimuli are tuned out, and one can ignore reality that does not impinge upon the organism too much. Going inside is in a regressive direction. This is also true when the patient goes inside into his brain, to free associate, which is different than true introspection. The latter is an active process involving work, the former a more leisurely activity, like cruising on a summer day. Psychoanalysis uses the wrong instrument, the brain, and goes in the wrong direction, increased insight. The regressive wish of the child within must find all the room in good therapy to be fully and powerfully experienced and expressed, but no room at all to be acted upon. The regressive push cannot be overcome without full, repeated and powerful expressions of the pre-verbal rage. This does not happen in analysis. So, at best, when all goes well in analysis the patient has a consistent and somewhat important relationship with a benign and well-meaning person for a few years, which is not bad...

RH: THERE IS RESIGNATION IN YOUR TONE...

RBL: Well, there's resignation in that relationship, as there is resignation in my tone. Resignation to reality is considered a good result in psychoanalysis. Resignation is better than panic and fear. But, it leaves patients without ever discovering their adult powers.

RH: I SUPPOSE YOU ALWAYS TRY TO SEE THE BABY BEHIND THE PERSON, ITS HUNGER, ANGER AND RESIGNATION. AND YOU TRY TO REVERSE THE RESIGNATION.

RBL: Yes. And in psychoanalysis the older, oedipal child is seen, instead. In the center of the psychoanalytic model are issues of fear expressed in terms of castration. Even if true, this is a late-life (age 5) concept. What we must deal with, instead, are fears of non-being, of engulfment and of abandonment. These are at the core of our patients' pathology, the bankrupt psychoanalytic model notwithstanding.