TAP

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“Many psychiatrists and psychologists refuse to entertain the idea that society as a whole may be lacking in sanity. They hold that the problem of mental health in a society is only that of the number of ‘unadjusted’ individuals, and not of a possible unadjustment of the culture itself.”

——Erich Fromm, *The Sane Society* (1955)

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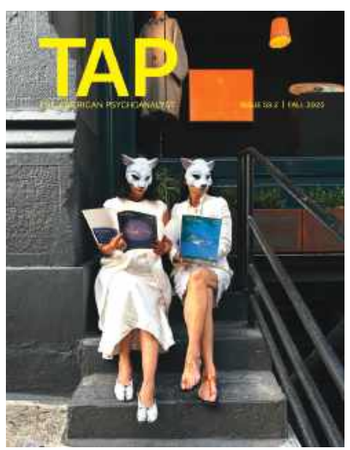
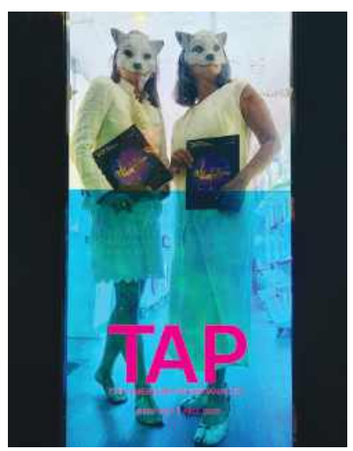
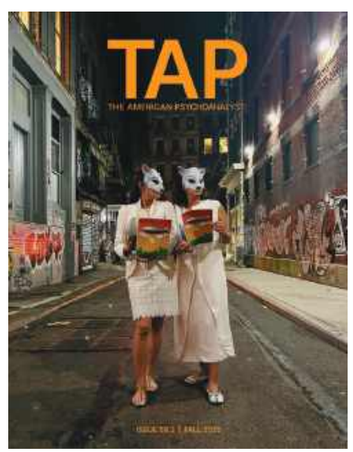
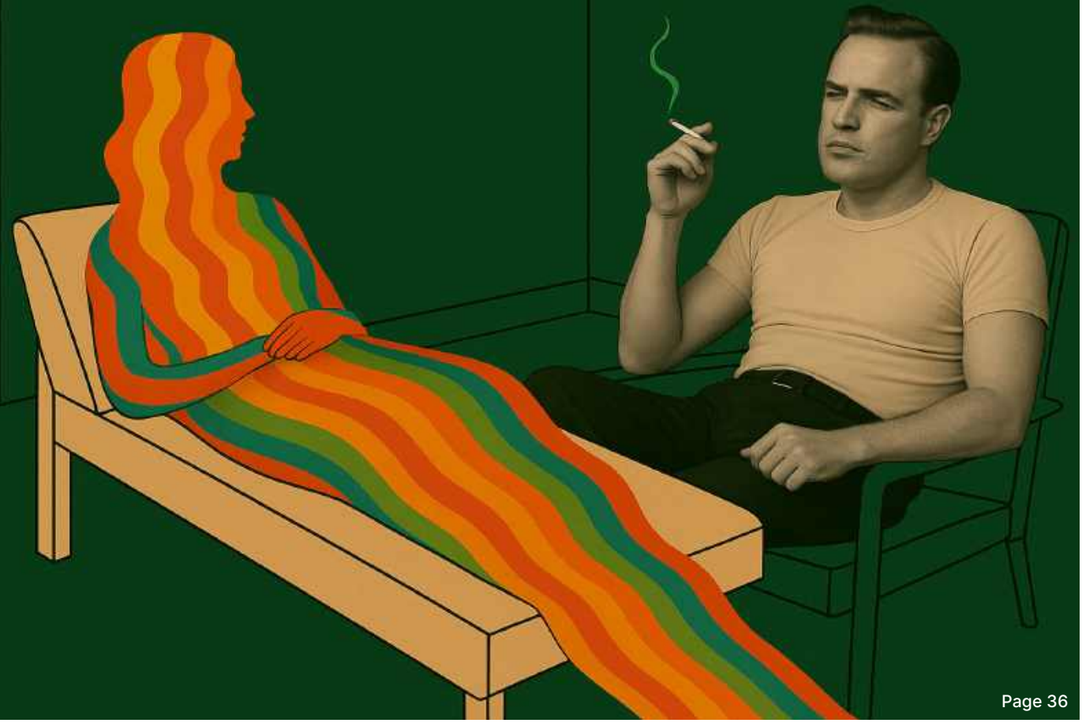
ON THE COVERS:
For 59.2, which delves into "the social" and samples psychoanalytic fashion, the *TAP* team took to the surreal streets of NYC for our first photographic cover shoot. Five hours and hundreds of shots later, we'd captured the lupine charisma of models Melissa Overton (*TAP* Design Director) and Tati Nguyen (*TAP* contributor) across four distinct magazine covers. (Which did you get? Collect them all!) Melissa wears a Zero + Maria Cornejo linen tunic and Maison Margiela painted Tabis, and Tati wears a Jussara Lee Hand-Me-Up blazer, Ulla Johnson vintage dress, and Yohji Yamamoto vintage vinyl sandals. Photography by Austin Hughes.









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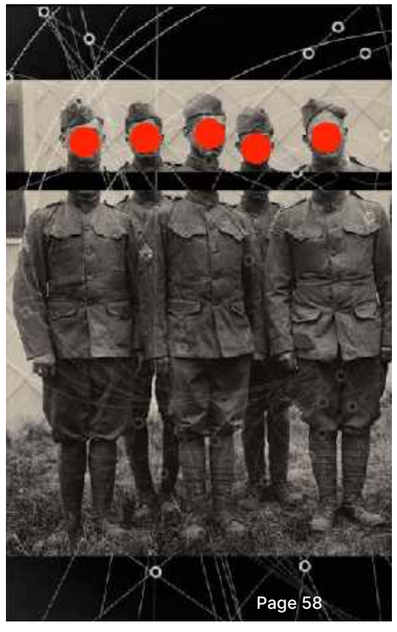

TAP THE AMERICAN PSYCHOANALYST

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WHERE IS MENTAL ILLNESS?

BY LUCAS McGRANAHAN


Photo by Austin Hughes

I'M A TRAINED philosopher, which means I like big questions of the form "What is X?" What is knowledge? What is reality? What is the good life? Expansive questions that promise to get to the heart of it all while putting everyday concerns in perspective. Maybe you asked your best friend questions like this at a sleepover in junior high lying on your back wired on Coca-Cola at 1 a.m. Maybe you wrote a term paper on Plato's *Symposium* in college (also at 1 a.m.). Maybe you're one of us who keeps returning to these questions in adulthood, hooked on ennobling abstractions.

What is mental illness?

That's a natural "What is X?" question for *TAP*. In reviewing the stories in issue 59.2, however, I'm more struck by another question in the neighborhood: *Where* is mental illness? Is it in the body, the mind, society, or somehow all three?

The biomedical model locates mental illness in the body (especially the brain), writes you a script, and sends you on your way. The point of view is objective and materialist. In the blunt words of 19th-century German thinker Karl Vogt, "The brain secretes thought as the stomach secretes gastric juice, the liver bile, and the kidneys urine."

Talk psychotherapy recognizes an interior dimension, the mind, which other minds can tune in to and address using words. Indeed, Freud developed psychoanalysis, the first modern talk therapy, based on the insight that illness can be caused by subjective states (such as intolerable ideas) and treated by subjective states (such as trains of associations leading to catharsis). The body is important as a canvas of symptoms and a wellspring of drives, but to miss the subjective is to miss something essential.

Having staked out and defended the interior world, are we in danger of getting stuck there?

Freud's focus, especially after ditching the seduction theory, was decidedly intrapsychic: Neurosis derives from conflict among different agencies of the mind. This viewpoint pushes a lot else into the background. Neurotic conflicts have roots in real family systems (e.g., the oedipal triangle), as Freud himself described. Beyond the family, small groups and larger social systems seem to have their own characteristic forms of pathology, which structure and inflect the suffering of individuals. Not to mention that the available diagnostic categories and therapeutic modalities are determined by dominant schools of clinical practice and insurance companies.


Photo by Micheal McLaughlin

Both human suffering and our tools for working through it are in some way social products.

The mind is tethered to a body that moves in a social world. You can squint at the whole complex of mind-body-surround from different angles for different purposes. What are our blind spots?

***

Today, analysts are being asked, with ever greater urgency, to pay heed to the social. Not everyone agrees on how to do this. In an April 2025 story in *Harper's Magazine,* Maggie Doherty draws the battle lines:

> On one side are the defenders of the old ways of doing things, of objectivity, rigor, and the universal human subject. On the other side are those who understand norms as culturally constructed. They often argue that the universal subject is always racially coded and that lived experience produces (or limits) certain forms of knowledge. This second camp usually suggests that the profession needs to find new and more equitable ways to do its work.

There are levels of diagnoses and demands here. There is the demand to both grow and diversify the field by attracting a wide range of practitioners and patients. More provocatively, there is the claim that sociocultural factors such as race and gender deeply structure human subjectivity, that clinicians must take these factors into account in treatment, and that even highly trained clinicians may be blinkered in significant ways by their own background.

"The social" in these discussions can sound like a hoary abstraction. **Richard Almond** helps provide clarity, distinguishing between (1) psychoanalytic theories of social phenomena (a form of social psychology), (2) the application of those theories to conflicts within communities, and (3) social issue advocacy by psychoanalysts. And **Max Beshers** takes up the social turn in psychoanalysis from the perspective of the Group Relations Conference, arguing that behavior we might pathologize in one person—for example, a racist enactment—is often carrying the unspoken tensions of a group. These stories can help us understand the terms of debate and work through, rather than repeat, group-level defenses.

What about the body? **Neal Spira** traces the failure to launch of psychosomatics—the study of feedback between mental and physical symptoms—in the US during the heyday of psychoanalysis. Spira looks to France for an example of psychoanalysts who still do psychosomatics, while in America the territory of the body is either ceded to biomedical science or is taken up by schools of therapy outside or adjacent to mainstream psychoanalysis. A path worth revisiting for US psychoanalytic researchers and clinicians?

In clinical practice, one way of centering the body is through the simple act of walking. **Lily Meyersohn** presents a deeply researched story on the meaning and benefits of walking therapy, questioning whether "Please take a seat" is always the right opening for a session. Another alternative therapeutic method, ketamine therapy, is explored by **Tracy Sidesinger** in an interview with psychoanalyst John Burton—the first entry in a planned series of interviews with clinicians on key issues of our times. Today, both walking therapy and ketamine therapy are practiced mostly by nonanalysts, but these pieces might pique analysts' curiosity.


Photo by Micheal McLaughlin

Another new series is our advice column Ask a Psychoanalyst, written by **Stephanie Newman,** who is fun and engaging as well as informative. Read the question about handling positive transference and submit your own question to advice@tapmag.org.

Austin Ratner introduces the Psychodynamic Research Mentorship Program (PRMP), a partnership of the Erikson Institute of the Austen Riggs Center and the Yale Child Study Center that nurtures young psychoanalytic researchers. The PRMP exemplifies a salutary scientific spirit that psychoanalysis has long been ambivalent about.

Xiaomeng Qiao surveys the role of "dead mothers"—Andre Green's phrase for mothers who seem emotionally absent to their children—in the lives and work of some major psychoanalytic theorists. Winnicott's theory, for example, was *not* based on his experience of a "good-enough mother."

Have you ever compared your therapist to Marlon Brando? **Adam Blum** examines a key idea in psychoanalysis and all talk therapy—listening—through a colorful, extended comparison of analysts and method actors, inspired by TV and film actress Robin Weigert.

Speaking of arts, we round out the issue with some striking fashion photography: a selection of images from the exhibition *Dress, Dreams, and Desire: Fashion and Psychoanalysis,* which runs at FIT in New York City until January 4, 2026; and a shot of the Sigmund Freud statue at Clark University, which is donning its own fashion.

Thanks for reading and for keeping psychoanalysis in style.

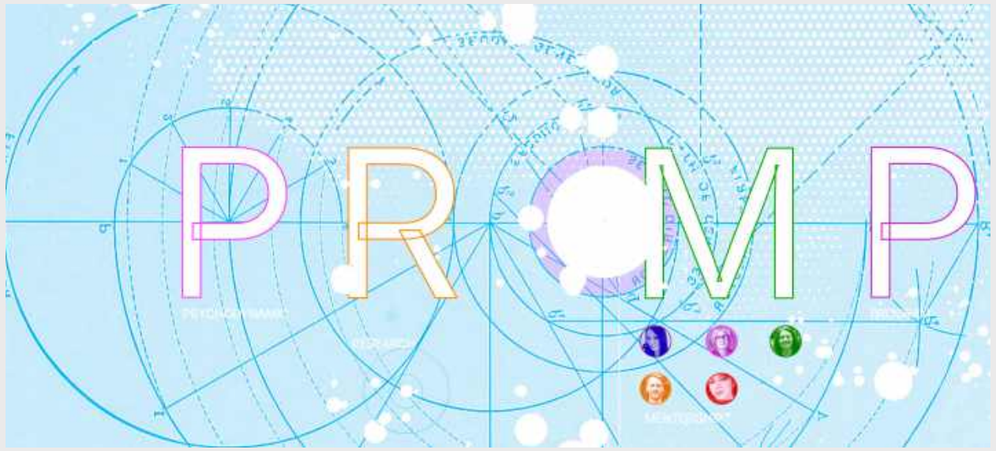
LUCAS McGRANAHAN

Supporting the Science of Psychoanalysis

Meet the people behind a global program cultivating the next generation of psychoanalytic researchers.

BY AUSTIN RATNER

Illustrations by Austin Hughes



"THE FACT IS that the public have an insatiable curiosity to know everything, except what is worth knowing," Oscar Wilde said. He was speaking in the first place of the public appetite for gossip, but also of the aversion to knowing anything serious or hard.

Scientific curiosity, unlike prurience, asks difficult questions. Linda Mayes, Jane Tillman, and Katie Lewis are three women animated by such scientific curiosity, and they are the organizing forces behind the Psychodynamic Research Mentorship Program (PRMP), a colloquy of talented young scholars and sage mentors from around the globe who just may represent the future of psychoanalysis.

A collaboration between the Erikson Institute of the Austen Riggs Center in Stockbridge, Massachusetts, and the Yale Child Study Center in New Haven, PRMP is carrying on a practice of scientific inquiry that's always been a part of the psychoanalytic community, one that's always faced obstacles but has always found a way to grow around them and flourish. Those with twin interests in clinical psychoanalysis and research have often found each other arbitrarily, like trees casting pollen on the wind. The PRMP is designed as a greenhouse to create more institutional stability and support for the growth of psychoanalytic research and researchers.

GROWTH AND DEVELOPMENT

Linda Mayes, a pediatrician, psychoanalyst, and chair of the hallowed Child Study Center at the Yale School of Medicine, has spent her career studying growth and development and nurturing it in both her patients and students. She's the motive force behind the latest incarnation of the PRMP, a program she's known since its infancy, as it were.

The PRMP's precursor was a series of meetings that took place at the Anna Freud National Centre for Children and Families in London where, once upon a time, an international group of psychoanalytic researchers gathered for two weeks each summer. In contrast to her father Sigmund, who purposely isolated psychoanalysis from the rest of academia, Anna Freud left behind a legacy of collaboration with researchers, pediatricians, and experimental psychologists that lived on at the institution bearing her name. Mayes participated in those colloquia alongside giants in the field of psychoanalytic research like Peter Fonagy. Participants presented their work and shared ideas, support, and resources. Mayes was then inspired to host an American version of the meetings in New Haven, which eventually pulled in clinicians from Austen Riggs who were interested in the clinical-research interface.

"We did it for a number of years," Mayes says. "And then interestingly, I think for a host of reasons, probably financial, application started dropping off."

When the COVID pandemic hit and meetings everywhere went virtual, Mayes saw an opportunity to breathe new life into the psychodynamic research and mentoring group.

"We were having our 30th anniversary celebration of the Erikson Institute last August," recalls her colleague Jane Tillman, director of the institute, which was founded at Austen Riggs by Ed Shapiro in 1994. At the anniversary meetings in Stockbridge in 2024, Tillman says, Mayes suggested they revive the colloquium that began all those years prior in London, refashioning it as a new training program in psychoanalytic research. Katie Lewis, director of research at the Erikson Institute, was "all in," Tillman says.

The program would be relaunched virtually over Zoom, they decided, facilitating participation from around the world, which it would attempt to attract under the prestigious auspices of the Yale Child Study Center and the Erikson Institute.

"That was one of the ways that Shapiro conceptualized the Erikson Institute," Tillman says, "as having a kind of convening authority."

They put the word out via Riggs's and Yale's networks, and applications came back from as far away as Nepal. Nine early-career researchers were admitted from all over the world, and each was paired with an experienced mentor. Today, they log in to meetings from Austin, Texas, and Klagenfurt, Austria; from Chicago, New York, Zurich, and Haifa. They are exploring psychoanalytic questions such as, "What defenses arise for parents? And how might clinicians help parents prevent their defenses from distorting the childcare they provide?" One project seeks to develop a reliable instrument for coding themes in patients' recitations of their dreams. Another studies bereavement in marginalized, underserved populations.

The researchers treat psychoanalysis scientifically. They talk about psychoanalytic ideas less in terms of theoretical jargon and more in terms of measurable phenomena. When discussing ego function and capacity for insight, for example, they speak of "reflective functioning" as measured by standardized questionnaires. While psychoanalytic clinicians have often taken a dim view of questionnaires as too crude or reductive to provide meaningful information, such standardized methods and language help support replicable scientific experiments and studies that in turn amass demonstrable evidence. New evidence can then help shape new theories and techniques, can help correct mistaken practices by questioning and disproving old dogmas, and can help guide policymakers. Evidence, in other words, is how researchers not only seek greater understanding of the world, but how they seek to change it. Many of the researchers in the PRMP accordingly have ambitious, idealistic aims.

Natalie Haziza, a postdoctoral fellow at Haifa University, writes in her research proposal, "My ultimate goal is to advance evidence-based psychodynamic and trauma-informed interventions, promoting social justice and inclusivity in psychological care."

Mareike Ernst, a professor at the Institute of Psychology in Klagenfurt, Austria, is trying to launch an international multicenter randomized controlled trial to study therapeutic change between therapy sessions.

The PRMP mentors provide granular advice—how to refine inclusion criteria for a particular study, for example, or how to construct a questionnaire to get the most useful data back. They also provide moral support.

At a Saturday Zoom meeting in June 2025, Ernst voiced frustration that in applying for a big grant, a lone reviewer had shot down her proposal. Whereas the other judges rated the proposal highly, this one was unfairly hostile to psychodynamic ideas, she said.

"I was a bit hurt by the grant rejection," Ernst admitted.

"I'm sorry that one person can be such an outlier and still determine the outcome," Tillman said.

"It's a brutal process," Lewis added, but she encouraged the young researchers to stay at it. "You guys represent some of the great minds coming up in this field," she told them.

Mayes sees the PRMP as an incubator of questions—and questioners. She does not think the mission of psychoanalytic research is to try to prove psychoanalytic principles that clinicians already endorse based on their anecdotal experience or on received wisdom. She thinks of psychoanalytic research as "asking questions informed by psychoanalytic theory," she says. "I ask them, what are the questions you'd like to know from your practice? … They haven't thought of [their questions] as research, but they're making hypotheses all the time."

CAST OF CHARACTERS

The PRMP's leaders are all, in a sense, paying forward the mentoring they received earlier in their careers. Mentorship and a hardy curiosity are the fundamental properties that have kept the psychoanalytic research community alive over the past century. And the life-stories of the mentors and mentees involved with the PRMP demonstrate the importance of both.

The Goth Girl: Katie Lewis

Erikson Institute Research Director Katie Lewis would not have entered the field of psychoanalytic research without the influence of strong mentors.

"The mentors that I've had," Lewis says, "they're all people driven by a very genuine passion and curiosity."

Growing up in Saratoga Springs, New York, Lewis had no intention to get a PhD in psychology or pursue psychoanalytic research.

"I thought I would be a creative type," she says. "I was in rock bands all through high school and college."

While studying fiction writing in college at the New School in New York, she turned to psychology courses to aid in the development of fictional characters. She ended up interning with psychoanalyst Leon Hoffman at the Pacella Parent Child Center on the Upper East Side of Manhattan, helping to look after the babies there. By then she was interested in graduate school for psychology, not fiction, and Hoffman introduced her to Wilma Bucci, whose research blended psychoanalytic and cognitive psychology ideas into a construct she's called "multiple code theory," a way of conceiving how emotion is represented in the brain and how its expression leads to therapeutic change. Bucci became a vital mentor for Lewis, demonstrating how an interest in language could be pursued not only artistically but with scientific methods like the lab-friendly numerical measures developed by Bucci's husband, mathematician Bernard Maskit.

"And that's where the dedication to empirical research and psychoanalysis formed," Lewis says. Wilma "was really kind and generous with me. She was struggling with questions I thought were really interesting. How do we put feelings into words? … I related to this idea that when you hit that right note, when you find the right words for the feeling, that there's a release that happens, there's this incredible process that happens that's important in therapy, but also important in life."

Jane Tillman, who has directed the Erikson Institute since 2013, remembers her first impression of Lewis as "kind of a goth girl coming to do a summer internship." Tillman and her colleague Jennifer Stevens were at the time studying Riggs patients who had attempted suicide, trying to identify signs of an impending suicide attempt so that clinicians could intervene beforehand. "Katie's first or second meeting in that lab," Tillman says, "we had a suicide of one of our patients the night before. And it was just grief. It was just a lot of weeping. It was horrible. And there's Katie, a second-year graduate student that we've never met before, sitting in on this. Jennifer and I did sort of laugh, later on. We were like, 'Well, we'll never see *her* again.'" But Lewis came back several summers and became essential to that project. "She used our data for her dissertation and the first publication to come out of our study was Katie's," Tillman says. "Now she's the director of research and she's just amazing."

The Dilettante: Jane Tillman

Who would've guessed that, in addition to being a psychoanalyst and psychology PhD who studies suicide prevention, Jane Tillman is also a trained hospital chaplain and a former helicopter paramedic?

"I'm a dilettante," she says. "But I don't think it's a nasty word."

More than a dilettante, she is as an intrepid adventurer with a zany sense of humor. Attired on the day we spoke in a white blouse with Carolina-blue stripes, she called her outfit "my Tar-Heel prison pajamas."

She acquired her devotion to the University of North Carolina Tar Heels as an undergraduate before going on to a master's degree in divinity at UNC's foremost rival, Duke.

I noted the transgression: "A Tar Heel at Duke."

"I know," she said, "it's terrible. I hate Duke."

After divinity school, she considered becoming a medical doctor or an ethicist. "I wanted to get a PhD in ethics, but it's super expensive and no job market. Nobody has need for an ethicist. Ethics is for losers, you know?" Sensing impending "financial ruin," she became a flight paramedic on a helicopter, which she loved. "But I thought, 'This is a young person's game.' You see these 50-year-old trauma surgeons in the middle of the night, and they are some unhappy, angry people." She gave up on the idea of med school and looked for another way to "bring together science and the mind and the spirit."

The answer she came up with next was to get a PhD in psychology from the University of Tennessee, Knoxville, whose faculty at the time were psychoanalytically oriented, a fact she appreciated. Her first required class assigned the Norton *Freud Reader,* Peter Gay's introductory selections from Sigmund Freud's writings.

"We spent the semester reading Freud," Tillman says, remembering it fondly. "Nobody does that in graduate school anymore." Her excitement about Freud's ideas did nothing to diminish her interest in quantitative science, however, and at Tennessee, that wasn't a problem. "I was in a class of people who were interested in trying to bring together psychodynamic thinking and research." The usual schism between the two didn't apply there at the time. "It helped that there's no American psychoanalytic institution near there. It helped to be isolated in East Tennessee doing your own thing. I was blissfully disconnected from the politics of American psychoanalysis and the world in some way."

One of Tillman's most important mentors in graduate school was Mike Nash, author of over 130 neuropsychology papers in journals from *American Psychologist* to *Scientific American*.

"He was very devoted to quantitative research," she says, "but he also was a guy who's interested in literature and interested in psychoanalysis." He taught classes in statistical methods and in Shakespeare. "There's not a big home for people like that anymore, but to have someone say you can bring the arts and sciences together in a meaningful way, that was so important."

Now that Tillman is herself a mentor, she passes on the sense of possibility to those who train under her. Still, the work is challenging. Treating suicidal patients can be devastating. Designing and staffing research projects, funding and publishing them, is no mean feat, especially when there are aversions to psychoanalytic research both inside and outside the field. I asked her how she picks herself up and carries on despite obstacles and frustrations.

"You surround yourself with Katies and Lindas," she told me. "I'll say something like, 'Well, it won't work because of this. And I'm worried about that. And I don't think there's going to be money over there. And people aren't going to sign up.' You know, I'm like Eeyore. And Katie and Linda say, 'Come on!'"

The Liberator: Tina Amiri

PRMP mentee Tina Amiri, who came to the United States from Iran in 2023 to pursue a PsyD at the Chicago School, and whose mentor in the PRMP is Jane Tillman, grew up with a lot of questions about the human mind.

"I was born in a family with mental health struggles," she says. As a young person, she was expected to care for her father, who had bipolar disorder with severe psychotic features. "He was a very successful architect at the same time. He was so smart and so kind, but that disorder is a devil and it can destroy everything."

When a friend died of a drug overdose, Amiri says, she began to think more deeply about a career in psychology. "He was an artist and he was an amazing person. He was kind, he was a beautiful person inside and out," she says, but she saw that he always felt lonely and disconnected. "When he passed away, it was a huge change in my life. I thought to myself, 'I really need to do something about people like this.'"

Growing up in Tehran, Amiri learned to look at the ruling regime in Iran itself in a similar light—as irrational and self-destructive. There was no putting the regime on the psychiatric couch, so she and her friends fought the regime in the streets.

"My friends were tortured at prisons," she says. While at university, she says, "Gradually I figured out you cannot understand what's going on here if you cannot understand the human mind."

When she began studying psychology, however, her courses did not seem to explore psychodynamic themes of human nature, like inner conflict or the influence of childhood on later life. "It was a huge disappointment. … I was almost about to quit." But a light went on when Amiri had a professor who was an expert in psychoanalysis. "I just felt, *Oh my god that is the language I understand*," Amiri says. "This is finally how this world can make sense and people can make sense to me."

After obtaining her master's degree in clinical psychology from Iran University of Medical Sciences, she came to Chicago to pursue a PsyD and applied to the PRMP at Austen Riggs.

"Psychoanalysis is my passion," she says, "seeing people free of their conflicts and everything that they had no choice in experiencing and just was imposed on them, you know, when they were a little kid and they were so vulnerable." Amiri talks about "all the true selves that are buried somewhere" underneath the false identities people construct to avoid fear and pain. Her clinical work and her research are all about finding ways to set those true selves free.

The Positive Attitude: Fritz Wienicke

Fritz Wienicke, another PRMP mentee, came to psychoanalytic research by a route very different from Amiri's. Growing up in Düsseldorf, Germany, about 30 miles from the Dutch border, Wienicke began his career in psychology at around age 12, in front of the TV. He was watching an episode of the American sit-com *Drake and Josh*, a show about two stepbrothers that aired on Nickelodeon for four seasons, starting in 2004.

"One of them was grounded and was so bored," Wienicke remembers, "and didn't have internet. He read a book about psychology and then the mother came home and then he made his own Rorschach test and analyzed her." Wienicke says he made his own Rorschach test with ink and used it with his whole family. "I just said some meanings and pretended to be super smart."

Wienicke learned about psychoanalysis from a friend of his parents who'd had psychoanalytic treatment, and also from his barber, of all people, whose interest in heads ran deeper than hairstyle.

"He would tell me about psychoanalytic concepts, cutting my hair," Wienicke says. As he began to read about psychoanalysis himself, it made sense to him. "I could see in my own family history, how things somehow made more sense from the psychoanalytic point of view."

It wasn't until he attended university in the Netherlands that he encountered some of the usual criticisms of psychoanalysis—"Some teachers saying, 'It's not evidence based, it's only about sex.'" Were that true, psychoanalysis would not have appealed to him. "I was always interested in statistics, in just doing science," Wienicke says.

While pursuing a research master's in clinical and developmental psychopathology, he became known among his peers for his singular focus. "Every single presentation, every single paper, I always did on psychodynamics."

There were challenges to being a psychodynamic researcher in the Netherlands, where cognitive-behavioral studies are easier to publish and meet with less resistance from reviewers than psychodynamic studies, he observes.

> Those with twin interests in clinical psychoanalysis and research have often found each other arbitrarily, like trees casting pollen on the wind. The PRMP is designed as a greenhouse to create more institutional stability and support for the growth of psychoanalytic research and researchers.

"If I give a presentation not for a psychodynamic audience, I always start by saying, 'Hey, it is evidence-based.' And then to clarify, it's not only about Freud. There's also other really great thinkers." He often directs doubters to Swedish professor Peter Lilliengren's compilation of more than 300 RCTs on psychodynamic treatment.

Wienicke's positive attitude sometimes pays off in surprising ways.

"When I started the PhD in the beginning, each PhD had to give a presentation for the whole department." In his presentation, Wienicke laid out his plan to do meta-analyses of psychodynamic data. "One professor said, 'Hey, but does anyone still do this? Is this relevant?' … I presented something, and he was always a bit critical, always making jokes, 'Again, psychodynamics!'"

Wienicke persisted and ultimately this professor invited him to give a lecture on psychodynamic psychotherapy to his students, encouraging the students to take an interest. "I got him a bit to the middle" in his attitude to psychoanalysis, Wienicke says, "or not as opposed to it."

The Green Thumb: Linda Mayes

At that Saturday Zoom meeting in June 2025 mentioned above, Linda Mayes, the pediatrician and chair of the Yale Child Study Center, referred to the PRMP as "a grand experiment that I hope will work."

Mayes radiates a quiet, healthful power, a slow timeless pressure on behalf of life like plant roots seeking water, growing through rock if they have to, and if they can't, growing around. She says she went into pediatrics in part because she was hospitalized with meningitis as a small child and carried with her a good feeling about the pediatricians who cared for her. But more than that, she's interested in development.

"Pediatrics is inherently about development," she says. "And it's about rapid change and it's about potential. That's why so many people go into pediatrics."

You can hear in Mayes's voice soft accents of the hills of southeast Tennessee, where she was born. She still maintains a farm there that grows soybeans, corn, and hay and hosts ecology students from Sewanee, aka the University of the South. In her free time, Mayes loves working with wood, building furniture. She hopes to begin working with lathes.

"Even after wood is cut and a tree is cut, it's still living in a way," she says. "It's a living thing. And I love bringing the grain out in wood and I just like building things."

I asked her how she feels about challenges and how she deals with adversity, both in the context of psychoanalytic research and personally.

"In the mentoring world," she says, "the challenge is how do we help our mentees become effective translators?" They have to be able to translate the language of clinical psychoanalysis into the language of scientific research—to be "conversant in the academy," as Mayes puts it—because there's still a divide between those two worlds.

"When [the mentees] really get the idea of asking the question," she says, "that's a great moment. I never tire of it. And if we can get them there, I think that's helping someone become a scholar, whatever their theoretical perspective. It's helping them become a critical thinking scholar. So to me, that's the goal."

Mayes adds, "Psychoanalysis is a field with enormous personal value and impact for me. I think it's a field or an approach that has helped many people. I would say that psychoanalysis hasn't done itself fairly in many ways by not adopting a spirit of inquiry, by being in some ways threatened by the academic research world. And vice versa, I think the academic research world has been relatively anti-intellectual in not adopting a spirit of curiosity about different ways of thinking about the mind."

Bridging the divide between clinical psychoanalysis and research, as Anna Freud, Peter Fonagy, Mayes, and others have done, creates spaces within the academy for psychoanalytic ideas to flourish and grow. But it requires a certain humility to admit that psychoanalysis alone does not possess all the answers. Having witnessed the deep oblivion of emotional life in so many areas of academic and public life, psychoanalysts sometimes assume a certain superiority—as when psychoanalyst Charles Brenner swept aside all of academic psychology as "of minor importance" in the introduction to his 1982 book *The Mind in Conflict*.

"Of all the practitioners, clinically, psychoanalysts should probably be the most humble, because they've seen the most," Mayes says. "They've seen human beings in their greatest complexity. They often are not the most humble."

Mayes combines in her own person an unusual capability for both humility and ambition. "My mom did have an expression, which was, 'Meet you at the next windmill,'" Mayes says, referring to her own idealistic streak. But she doesn't feel she's tilting at windmills when she's doing psychoanalytic research or training young researchers or building academic bridges. She doesn't view the work as part of some intractable conflict or crusade. She views it more as a pediatrician would. It's about growth and development. ■

Austin Ratner *is a contributing editor for* TAP *and author of* The Psychoanalyst's Aversion to Proof *and a recent essay in* JAPA *titled "Attention Must Be Paid."*

Collage by Austin Hughes. Source work: William Dyce, *Madonna and Child,* 1827–30.

THE SHADOW OF THE DEAD MOTHER

HOW MATERNAL ABSENCE SHAPED PSYCHOANALYTIC THEORY

BY XIAOMENG QIAO

Once, stretched out on her lap
as now on a dead tree
I learned to make her smile
to stem her tears
to undo her guilt
to cure her inward death
To enliven her was my living.
—from "The Tree" by Donald Winnicott

A CURIOUS PATTERN emerges when one looks closely at the lives of influential psychoanalytic theorists. Many who built frameworks for understanding mother-infant relationships carried within themselves the wounds of what André Green would later call the "dead mother complex." Ironically, their theories often stemmed from personal encounters with maternal emotional absence—a phenomenon where the mother, though physically present, becomes psychologically inaccessible to her child.

The irony is both poignant and profound: The very theorists who illuminated the critical importance of maternal emotional presence often did so through the shadow cast by its absence in their own lives. This essay explores how the "dead mother" shaped not only the personal lives of key psychoanalytic thinkers but also the theoretical landscape they created—a landscape that continues to influence how we understand human development and emotional wounds today.

THE DEAD MOTHER'S ECHO

André Green's theory of the dead mother describes a specific form of maternal loss where a mother, due to her own trauma, depression, or psychological struggles, becomes emotionally "dead" while remaining physically present. The mother's gaze turns inward, leaving the child with an experience of psychological abandonment. This emotional void creates lasting trauma, often triggering narcissistic defenses as the child attempts to fill the emptiness through internal omnipotence. "The subject's entire structure," Green observes in his essay "Dead Mothers," "aims at a fundamental fantasy: to nourish the dead mother, to maintain her perpetually embalmed." Behind that desperate caretaking lies what he calls "an inverted vampiric fantasy": *the patient spends his life nourishing his dead; keeper of the tomb, sole possessor of the vault, he repairs her narcissistic wound in secret*. The child thus becomes guardian and rescuer of the very absence that wounded him in the first place, binding his psychic energy to reviving a mother who can no longer revive him.

Green's conceptualization didn't emerge from clinical observation alone. His mother experienced profound trauma when her sister was burned alive—Green was only two years old at the time. Following this tragedy, his mother descended into prolonged mourning and psychological withdrawal, becoming emotionally distant and unable to respond to her son's needs. Green's experience of maternal emotional coldness planted seeds that would later flower into his theoretical exploration of maternal absence. The quiet agony of the dead mother experience carries intergenerational consequences, shaping how we understand ourselves and others. For Green and other theorists, it became a lens through which they viewed human development, attachment, and the formation of the self.

Kohut: Self Psychology

From the frozen silence of Green's dead mother, we turn to a different wound—one disguised by an intrusive, over-bright mirror. The mother of Heinz Kohut, father of self psychology, was narcissistically intrusive rather than withdrawn, creating an emotional enmeshment that hindered his psychological independence. As Kohut described in his thinly veiled autobiographical case "Mr. Z," this excessive maternal closeness prevented healthy self-development and emotional autonomy.

Kohut's mother exerted a suffocating, narcissistic hold over him in his early life—emotionally invasive yet cold. This childhood experience profoundly influenced his academic path, particularly his research on narcissism. Kohut's self psychology explored how individuals develop a sense of self through relationships with "mirroring selfobjects," typically the mother. When this mirroring becomes deficient—whether through absence or intrusion—the child may develop narcissistic defenses to protect a fragile self-structure. In her final years, Kohut's mother descended into a persecutory psychosis, likely a form of paranoid schizophrenia. This late unraveling gave stark shape to the madness he had long felt but never named—transforming his position from trapped son to witnessing analyst.

Standing on that personal ground, Kohut formulated three selfobject needs—mirroring, idealizing, and twinship—each a strand of healthy self-cohesion. His mother's engulfing affection oversupplied mirroring yet starved idealization; Heinz could bask in her admiration but never borrow her strength. The result, he later wrote, was a "horizontal split": outward brilliance masking an inner diffuseness. Treatment therefore centers on *transmuting internalization*—the analyst offers just-right reflection until the patient can carry it inside, lowering the mirror without shattering the self.

Winnicott: The Good Enough Mother

If Kohut teaches us how an over-bright mirror can fracture the self, Winnicott invites us to consider what happens when the mirror dims and the child strains to keep its image alive. Donald Winnicott's relationship with his likely-depressed mother Elizabeth offers another variation on this theme. In his poem "The Tree," Winnicott recalls shouldering the responsibility of bringing joy to his mother as a child—a reversal of the natural parent-child dynamic. His emotionally distant mother and aloof father left Winnicott acutely sensitive to the nuances of mother-infant relationships from an early age.

This experience informed Winnicott's "good enough mother" theory, which asserted that while mothers need not be perfect, they must provide sufficient emotional attunement during critical developmental periods. From insufficient attunement Winnicott traced the birth of the False Self. It begins as a courtesy shield: The baby senses the mother's fragility and tones down spontaneous gestures to keep her engaged. Linked to this is his idea of Transitional Objects—the teddy, blanket, or rag that carries the child through the perilous gap between "me" and "not-me." Held at bedtime, nibbled in daylight, the object is both invented and found: part mother, part self, and a rehearsal for later creativity. Winnicott called this middle territory the "potential space," where play, art, and religion live. If the object is taken away too soon—or never invested with meaning at all—the self stays split between false compliance and isolated omnipotence.

Daniel Stern: The Silent Year

Winnicott's attunement to the mother's micro-failures sets the stage for Daniel Stern, who would slow that dance of faces down to a hundred frames per second. Daniel Stern's experience offers perhaps the clearest embodiment of Green's dead mother concept. Shortly after Stern's birth, his mother emotionally collapsed following her father's death, creating a profound rupture in their nascent bond. According to accounts shared by Stern's wife, his mother didn't speak to him for an entire year—a dramatic manifestation of maternal absence during a critical developmental period.

Throughout childhood, Stern encountered his mother's significant shifts in mood, sometimes engaged, sometimes cold—a pattern typical of depressed mothers. This emotional inconsistency became the seedbed for Stern's later research on mother-infant interactions, particularly how maternal emotional responses shape infant psychological development. Stern observed that when a mother's emotional presence is unpredictable, infants develop adaptive strategies: seeking connection when the mother is available, self-regulation when she isn't.

Filming mother–infant play frame by frame, Stern coined the phrase "vitality curves" to chart the ebb and flow of shared affect. Depressed mothers flatten that curve; their faces dim unexpectedly, just as his own mother fell mute for a year. Babies stretch toward any flicker of contact, then recoil into solitary regulation—patterns Stern named RIGs (Representations of Interactions that have been Generalized). In adult treatment a client may feel the therapist has "switched off" and instantly brace for abandonment. By recognizing the old rhythm inside the session, analyst and patient can co-compose a steadier beat.

CREATIVE REDEMPTION

This exploration of psychoanalysis through its pioneers' mothers is guided by a profound insight: Many cornerstone theories in the field were birthed through personal wounds. These theories weren't merely academic exercises but rather attempts at psychological integration—efforts to metabolize and make meaning from early relational trauma.

Through their theoretical contributions, these psychoanalysts transformed personal pain into universal understanding. Their work reveals how narcissism functions not merely as self-absorption but as a defensive response to the mother's—or, as we might prefer to say now, primary caregiver's—emotional absence, a way children protect themselves when the primary mirror for self-development becomes distorted or unavailable. Their theories weren't merely professional achievements but also personal reckonings—attempts to understand and integrate their own developmental injuries.

In this light, psychoanalytic theory itself becomes a form of creative redemption. Through intellectual exploration, these theorists reconstructed what was missing in their early lives, creating theoretical containers for experiences that once seemed uncontainable. Their work demonstrates how human beings can metabolize even profound relational trauma into meaningful contributions.

Interestingly, mothers were more peripheral in earlier Freudian theory. As Peter Gay notes, Freud himself never fully worked through his unconscious attachment to his "formidable" mother; across the case studies where he probes parent–child bonds, the mother is routinely pushed to the margins—present only as a faint backdrop while the father occupies center stage. Her conspicuous absence suggests its own form of psychological defense—an unconscious avoidance of confronting the powerful maternal imprint on his own development.

This history carries an important reminder: Our theoretical orientations often reflect our personal wounds and healing journeys. The theories we find most compelling may resonate precisely because they speak to our own developmental experiences. Recognizing this connection invites a deeper level of self-reflection in clinical work. ■

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Psychoanalysis and the Social

Sorting out theory, application, and advocacy

BY RICHARD ALMOND

Photography by Micheal McLaughlin

IN THE HEYDAY of psychoanalysis's popularity in the mid-20th century, pronouncements by analysts were taken as the final word on what was happening in the mind. As the new millennium approached, some leaders urged modesty about its claims. "Complacency has become more difficult for us, and modesty more seemly," said Edward Weinshel looking at our discipline in 1991. This caution is more apt than ever as psychoanalysis increasingly grapples with the world outside the psyche and the office—what is referred to with the broad term "Social." How prepared are we to take on this realm? Although Freud speculated broadly about group and societal phenomena in his later years, he did not provide much theoretical structure. Most mental health training omits formal attention to social phenomena (except social work, where training often includes systems awareness and community engagement). For many of us, this is new territory.

Psychoanalysis has historically shown animosity to individuals who proposed ideas about the Social. Psychoanalytic leaders in the mid-20th century, concerned about codifying and regulating a new profession, felt a need to protect the field from any dilution of its intrapsychic self-definition. Dissenters were ignored or excluded. Many of the prejudices and caste elements of society were repeated in psychoanalytic organizations. Fortunately, we now acknowledge that the individual is embedded in multiple layered and overlapping social systems. Organized psychoanalysis has recognized embedded biases like racism and homophobia. In the intellectual realm we see a need for learning and training about social phenomena. IPA, APsA, and component societies are making active efforts towards inclusion and curricular recognition. The Social is with us. But what is the Social?

The Social is complex. The individual interacts—both externally and intrapsychically—with a range of social groupings: *dyad, family, small group, organization, class, religion/race/ethnicity, political party, culture,* and *society.* Any or all of these may bear on a particular moment or ongoing phenomenon. For example, one or more of these may be salient in a treatment encounter. Or in our organizational membership practices. We can also identify psychosocial themes that cut *across* these levels: violence, racism, power, or leadership, for example.

To understand and intervene in these dynamics, psychoanalysts can contribute in three areas: (1) *social psychoanalytic theory,* (2) *community psychoanalysis,* and (3) *social advocacy*. What I discuss here are distinctions among these three realms of the Social in psychoanalysis—theory, application, advocacy.

Psychoanalysis is moving into an exciting, challenging era, melding our historic focus on the psychological, subjective insides with this newer recognition of the individual's social context. In this move, with modesty in mind, we can look to neighboring social science disciplines—social psychology, sociology, anthropology, political science, history, and economics. We don't have to reinvent a special psychoanalytic Social. But by virtue of psychoanalysis remaining largely outside academia, it offers a unique capacity for breadth and synthesis. We can develop a "psychosocial analysis." It will be a more responsible, powerful, and precise discipline if we keep in mind the distinctions, the sorting out, that I will present.

I. THEORY: SOCIAL PSYCHOANALYSIS

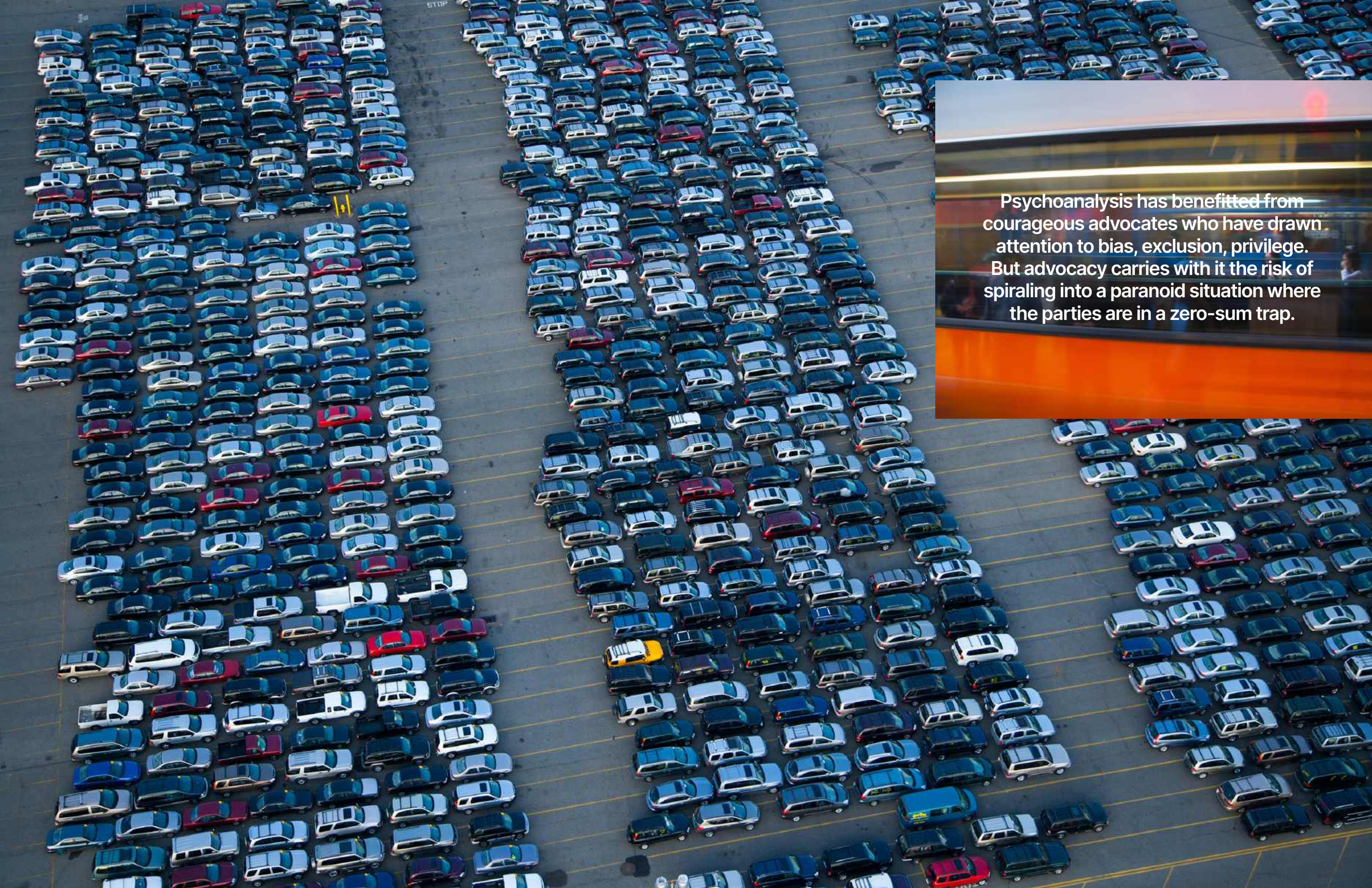
I suggest the term *social psychoanalysis* for our theory models of multiperson phenomena and their connection to the intrapsychic. Here's a familiar example at the level of the dyad: *transference*. In his most definitive discussion of the idea, the paper "The Dynamics of Transference" in 1912, Freud used the term in two ways. He said that transference is the unconscious projection of past relationships onto present interactions. *And,* he used the term to describe the interpersonal process that goes along with this projection—the analytic situation facilitates an interaction that repeats something the patient carries inside (we now see that the therapist has a subjective contribution, too). Most other modern psychoanalytic theories have included or added the social to the intrapsychic: the *ego* as first mediator with the outside; *object relations* theory; Kohut's *selfobject;* Lacan's emphasis on *language*. Interpersonal and relational groups have made dyadic processes central to their theory models.

Social psychoanalysis is akin to theories in social psychology or social psychiatry. Historically, Alfred Adler and John Bowlby had early experience working with delinquent youth alongside their analytic training. In their conceptual writing they were highly aware of family and peer cultural factors. They made significant contributions to analytic thinking about power and attachment, respectively. Both had a strong social emphasis; unfortunately, the ideas of both men were excluded from mainstream analytic thinking in their time. But in recent years Bowlby's attachment theory has garnered analysts' attention as research on infant-mother interaction provides understanding of children's and adults' psychology. The psychoanalytic study of power is less developed, and at a time of fragile democracy deserves attention.

Going beyond the dyad, analytic models of family and small group function again seek to conceptualize the individual psyche in processes of a cluster of other people. Wilfred Bion's *Experiences in Groups* provides an analytic model of processes at this level, distinguishing groups' intended functioning ("work group") from blocked functioning (Dependency, Fight-Flight, Pairing). The study of individual-organizational function has been taken up by the Tavistock Group.

After World War II there was interest in "national character," questioning whether there was a differential susceptibility to fascism, for example. *The Authoritarian Personality* by Theodor Adorno et al. in 1950 was an effort by social psychologists to identify a general personality type that would be susceptible to fascist ideologies and resulting mass movements. Erik Erikson's studies of national character and his psychobiographies of Mahatma Ghandi and Martin Luther link psychoanalysis with religion, colonialism, and historical change. Erikson's works stand as nuanced versions of what he calls *psychohistory*. He delineated the complexity of such studies, attending to the interwoven contributions of individual psychology, family background, social class and caste, and historical moment. More recently there have been efforts to frame racism and caste in psychoanalytic theory.

My own involvement with theorizing in the Social has involved a study of values and acculturation in a psychiatric therapeutic community. In my book *The Healing Community,* I developed a general model of acculturation to a special group. I began with studying how patients entering a psychiatric therapeutic community adopted its values, and how that process contributed to internal change. I supported the model with cross-cultural parallels such as "medicine societies" among the Zuni and a healing cult in Ethiopia. Terms borrowed from sociology and anthropology—"healing charisma" and "communitas"—were useful in characterizing a special sort of social-individual interplay. This was an elaboration of a *theory* of individual psychological influence through group action. Although my descriptions of clinical services contained helpful



Psychoanalysis has benefitted from courageous advocates who have drawn attention to bias, exclusion, privilege. But advocacy carries with it the risk of spiraling into a paranoid situation where the parties are in a zero-sum trap.

"how-to" information for leaders of groups and organizations, my focus was on *understanding* the individual-group process and developing a general model.

Currently there is theorizing of "racial" issues in intrapsychic terms—"the social unconscious," "Black rage" or "pathologic whiteness." Whatever one thinks about the validity or utility of such terms, they reflect an interest in conceptualizing the psychologies involved in the "racial" division of American society. (We now understand that the term "race" has no scientific standing and is a construct of groups seeking to separate others and hold power and status over them. Hence the quotation marks.)

I hope it is clear that *social psychoanalysis* is an immense realm of thinking and modeling. Potentially there is cross-fertilization between intrapsychic and social theories. Psychoanalytic awareness of intrapsychic phenomena such as drivenness, ego defenses, attachment, and internal object relations can contribute to the understanding of how the individual behaves in a small group or mass situation. In the other direction, understanding from the social sciences can inform us of conditions, pressures, and attitudes that affect the psyche, and they can provide language and structure. Many of these links may be further developed, particularly border concepts that have an element of both the internal and the social like *power, norms, roles, beliefs.*

II. APPLICATION: USING SOCIAL PSYCHOANALYSIS OUTSIDE THE OFFICE

Application to Training

When we move into the action realm, we are dealing with *applied social psychoanalysis.* Psychoanalytic centers in Boston and San Francisco have developed community training tracks as an option for candidates. A candidate who elects this track works with the staff of a social agency, providing an analytic perspective on clients and/or staff groups. Faculty experienced in agency consultation provide supervisory backup. Learning flows up and down through this system of client-agency-candidate-supervisor. This was my own experience consulting for a community mental health agency in Palo Alto, California. I brought understanding of individual dynamics to staff groups; my knowledge of social phenomena and concepts also enabled me to provide group/social system consultation. The experience increased my skills at the organization/individual interface.

Application to Political Conflict

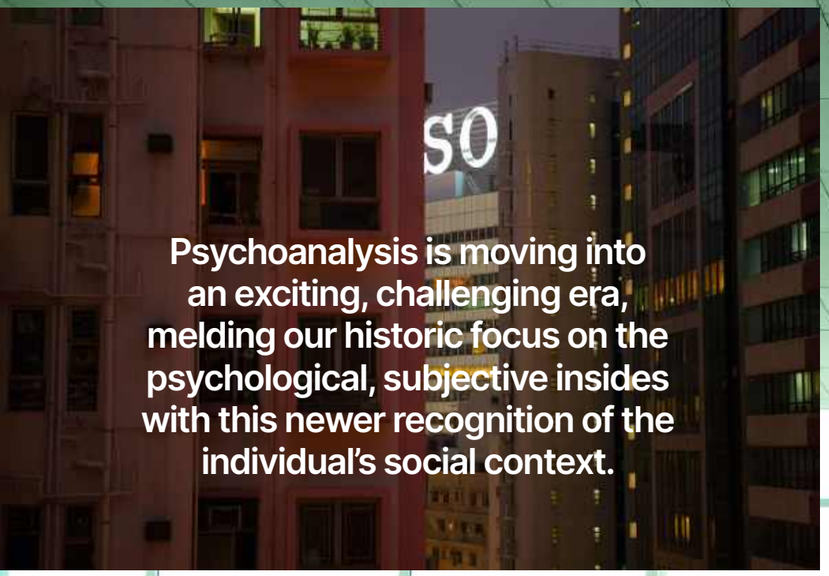
One of the key participants in negotiations between the warring parties of the Troubles in Northern Ireland was John, Lord Alderdice, a psychoanalytically trained psychiatrist and determined peacemaker. In the rancorous process that led to the 1998 Good Friday agreement, Alderdice recognized the importance of listening to both aggrieved parties, and insisted they listen to each other. He set a frame for the often bitter, insulting, provocative conversations that was private and confidential. His psychoanalytic understanding of trauma, shame, and affect regulation informed his guidance of peace talks, and in containing continued bitterness after an agreement was signed. Alderdice understood that the injuries and passionate beliefs of both parties could not be suppressed, but that they could be contained. The peace has largely stuck.

Application to a Hospital Setting

Here is an example from my experience applying social psychoanalytic ideas to a hospital ward situation. I was assigned to be the administrator of a psychiatric inpatient unit at the National Institute of Mental Health. I quickly became aware that there was competition between the nursing staff—many of whom had worked previously on a therapeutic milieu unit where they felt empowered—and the psychiatric/psychology staff who did individual and family therapy with inpatients. Both groups felt that their mission was the most vital. This led to each group ignoring or undercutting the other. The unit had a high level of threatening and violent patient behavior; there were two seclusion rooms. Having read several studies of patient-group processes in such units, I concluded that the behavior of our patients reflected the staff schism. Like children who may express anxiety about parental strife in naughty, limit-testing behavior, the patients acted up because their staff "parents" were fighting. I instituted a system of small staff meetings focused on a few shared patients. Both groups were represented, with the goal of arriving at understanding of each patient's dynamics *along with developing a working strategy together.* Over a few months the unit's violence level came down, and we were able to close both seclusion rooms.

III. ADVOCACY: TAKING SIDES

In the era when anonymity and neutrality were foremost aspects of the analytic role, reticence about political or social values tended to carry over to norms for public behavior. Analysts divided over theory models, with the divisions splitting institutes, or bringing about whole new organizations, but we did not comment as much about politics outside psychoanalysis. Now the divisive issues concern social externals like race and ethnicity. In other words, analysts are like everyone else—polarization and heated partisanship have become normal. Interest groups express their presence and expectations of inclusion and power sharing more vigorously.



Psychoanalysis is moving into an exciting, challenging era, melding our historic focus on the psychological, subjective insides with this newer recognition of the individual's social context.

Analysts have recognized the internal biases that used to justify discrimination against non-MDs, LGBT individuals, women, and nonwhites. Each of these struggles has forced analysts' attention to the impact of power differences and their roles in institutional behavior. We have left neutrality and taken sides. In a similar manner analysts have reacted to American or Israeli-Palestinian politics and violence in a split way, with some analysts identifying with one group or the other, while some attempt to mediate. Without commenting on any of the particulars in these situations, I want to emphasize that in these important controversies what is going on is advocacy on behalf of ideas, interest groups, and causes—something different from theory or application.

Psychoanalysis has benefitted from courageous advocates who have drawn attention to bias, exclusion, privilege. But advocacy carries with it the risk of spiraling into a paranoid situation where the parties are in a zero-sum trap. We know these dilemmas in the relationships of our patients, and sometimes the stuck transference-countertransference impasses of our own work. At the national and international levels we see division leading to war and genocide. Perhaps the answer comes back to Alderdice's strategy of "enforced listening." As analysts we have developed capacities for such listening with our patients, for containing passion and delaying action long enough to absorb what we hear, and how it makes us feel. This will be important as we reexamine our governance practices, build the Social into training, and consider where it fits in the clinical situation.

MOVING FORWARD

A reminder of modesty. I once led a case study group in which a South American–raised therapist presented her therapy work with a patient who had grown up in France, the child of Swiss and Iranian parents. The members of my study group themselves represented more than half a dozen ethnicities and nationalities. We could, of course, do no more than touch on a few of the familial, cultural, and developmental aspects of the treatment, along with considering the unique fit of two personalities. We hardly had time to digest the role of diversity within the study group, how the cultural perspective of each member of the study group might be affecting their perception of the case. This brings us back to the modesty with which I began. Just as the psyche is infinitely complex, so too is the social surround in which we treat and discuss. The task is to heighten our awareness, and to maintain that awareness steadily enough so that we begin to intuit the most salient social factors at a given moment.

The distinction between theory (social psychoanalysis), application (community psychoanalysis) and psychoanalytic advocacy is vital. The enterprise of psychoanalysis as a field of thought, models, and theories rests on a conviction that, both clinically and theoretically, analysts move between subjectivity and a striving for objectivity. This tension is reflected in the number of theories that say that the crucial element in the treatment process is the movement between passion and reflection, beginning with Freud's recognition of transference/countertransference and the role of interpretation.

When psychoanalysts are acting politically, this distinction becomes especially important—for example, as we begin the challenging task of finding a place for the Social in our curricula. On the applied side, we need to consider how to help analytic students recognize and respond to issues of family, ethnicity, and politics in their offices. Does teaching the Social mean systemic racism, or might we teach about status, class, power, and bias as ubiquitous? Or is this advocacy in the name of theory? If this is teaching social psychoanalysis, is it the best way? Would less loaded subject matter provide wider awareness and sensitivity? If we acknowledge the almost infinite complexity of the Social, what is the best way to teach about it—recognizing that we cannot provide students with multiple PhDs?

Each aspect of the Social is important. Although sometimes more than one bears on a given situation, it will be vital to bear in mind the three different meanings of the psychoanalytic Social: theory, application, and advocacy. The Social is a challenge for psychoanalysts. At the same time, the upsurge of interest in the Social is an opportunity for enrichment of psychoanalytic theory, teaching, and action. In any aspect of our lives as analytic therapists—in our offices, in our organizations, in the community, in our political life—it is useful to keep clear which realm we are in. If we can do this, I believe that there is a greater chance that the Social will have a lasting place, and not be the psychoanalytic excitement *du jour*. ■

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Navigating the Social Turn

Can the Group Relations Conference revive psychoanalysis?

BY MAX BESHERS Illustrations by Austin Hughes

IN A RECENT ISSUE of *Harper's Magazine,* Maggie Doherty describes a meeting of the American Psychoanalytic Association (APsA): "The crowd seemed old, strikingly so … Almost every person I saw was white." She goes on to describe a community that appears to be at risk of coming apart over discussions of racism. Shortly after that 2023 meeting, the organization experienced a painful and very public racial and political enactment that was ostensibly about Palestine, but for many symbolized deep disagreements about race in psychoanalysis writ large: Do we take up race and other social realities, often dubbed the "social turn," or do we insist that such content is not psychoanalytic because it ventures outside of the individual psyche?

In the aftermath of the 2023 conflicts, many younger and more diverse clinicians who had been pushing for the field to engage with social issues left APsA altogether. For those of us who care about the future of psychoanalysis, and who know that future must involve reckoning with systemic racism, the picture is grim: a community that can barely acknowledge its own lack of diversity without splintering. There is clearly a group-level defense against race and other social realities that is brittle, and potentially destabilizing when breached.

And yet APsA does not represent all of American psychoanalysis, as many institutes are not affiliated with the national organization. Bolstered by the groundbreaking *Final Report of the Holmes Commission on Racial Equality in American Psychoanalysis,* some institutes have had more success in navigating the social turn that threatened to tear APsA to pieces, but when only an estimated 0.2 percent of American psychoanalysts are Black, there is still a long way to go.

If we seek even greater fluency and maturity in conversations about race and the unconscious, I suggest we look to the Group Relations Conference (GRC) in the Tavistock tradition: a small corner of the psychoanalytic world, forgotten by many analysts or never known in the first place, but vibrant nonetheless.

THE GROUP RELATIONS CONFERENCE EXPERIENCE

The GRC experience consists of a mix of smaller process groups and larger group events, typically held over the course of a long weekend. With a focus on studying unconscious group dynamics in the here-and-now, GRC members welcome the sort of painful group interactions that most of us would rather avoid, seeing them as learning opportunities. Like an analytic session, GRCs have a frame to organize the experience. Consultants start and end each group session exactly on time—and are known to get up and leave right on the hour, even if a member is midsentence. This can feel brusque to the uninitiated but provides a sense of clarity and predictability about boundaries. Similarly, the consultants work very hard to stay in their roles at all times, with neutral facial expressions, in order to facilitate member learning. Members, on the other hand, are encouraged to use the space creatively to facilitate their learning about power and authority—even if that means arguing with management about the conference rules.

At a recent GRC that I attended in a large American city, the membership was quite racially diverse, and members came ready to talk about race, not as an abstraction "out there" but as a real thing happening *right here*. In a political moment where any sort of conversation about identity is under attack, it's hard to overstate how refreshing and healing it felt to encounter this radical openness. It felt like freedom. The humdrum university classrooms where we gathered transformed into laboratories for unlocking human potential. A consultant explained to one of my small groups that the conference is a space to explore one's own liberation, and that it looks different for everyone: yes, liberation from racism, but also from all the other arbitrary limitations that we unwittingly impose on ourselves in group life. The aim is to be our most effective selves in groups. After all, it is within groups—including psychoanalytic institutes—that we usually make important decisions about human society.

Groups are hard. The intensity of feeling that the GRC experience can stir up often comes as a surprise to newcomers. Even for those of us who have spent quite a bit of time in our own therapy and think we know ourselves well, group work can activate new parts of our experience that don't typically arise within the analytic dyad. Starting in the 1950s, British analyst Wilfred R. Bion used Melanie Klein's intervention methods to study groups. He found that group life has its own unconscious process, greater than the sum of its individual members, that exists in between the fear of engulfment and extrusion: that is, the fear of being swallowed whole by the group and losing one's identity and the fear of being cast out and scapegoated. At either extreme, the survival of the individual member as such is at stake, and infantile annihilation fantasies can easily be activated.

When we add conversations about race to this mix of primal fears, it's no wonder that even skilled people get overwhelmed. I have watched brilliant psychoanalysts regress very quickly when asked to discuss race and power in a group. At the GRC I attended, members described a large group event as a "firing squad" and a "killing field." Group work really is this fraught and this challenging, so why should we expect it to be different in our institutes?

Analysts get a lot of training about how to navigate complex dynamics between two people, but very little about how to do it in groups. If conversations about race and psychoanalysis often devolve into regression and chaos, the good news is that Group Relations practitioners have had technologies to address this problem for quite a while now. It's time we used them.

It is not only the field of psychoanalysis that stands to benefit. If we can figure out how to effectively process racial enactments, and teach the skill to others who need it, we could make a meaningful difference in the world.

WORKING THROUGH AN ENACTMENT

In one of my small groups at the conference, we had an opportunity to study this type of enactment together. After a group challenge exercise that involved moving around the room, a white member said casually to a Black member, "I saw you twerking just now." The Black member responded with confusion and dismay that her walking across the room was interpreted in this way. As a group we named this as a racially coded attack, made without conscious awareness. It was no surprise that this should happen, since groups are a microcosm of society. What moved me deeply was our ability to sit in the pain together and process it. To her credit, the white member owned that she had attacked the Black member. Her willingness to take responsibility, along with guidance from our staff consultant, opened up space for us to see the incident as a group-level phenomenon. Other white group members began to acknowledge that talking about racism as we had been doing made them uncomfortable, even angry.

The more that other members expressed their individual feelings, the more the burden was lifted from the two participants in the enactment. The group realized that it had unconsciously elected these two members to play the roles of perpetrator and victim, to express the latent anger about having to discuss race that white people in the group had been holding. Or to put it another way, the group felt that it needed to cast someone out in order to cohere. There were few dry eyes in the room as we grieved the pain of this, but we did not fall apart. In naming and owning our unconscious racism, we were able to work with it and transform it.

As I reflected on this incident later, I considered how many racial enactments are never resolved, leaving all participants feeling worse off, even though the theory about how to effectively work through such moments has been around for a long time. I thought of the brilliant work of the late Black psychologist Leroy Wells Jr. In his book chapter "The Group as a Whole: A Systemic Socioanalytic Perspective on Interpersonal and Group Relations," he explains how a group-level assessment can open up new possibilities for resolving group conflicts, including racial enactments.

In his case example, a seemingly intractable battle between two group members could be seen as a story about two personality-disordered individuals who are mired in their own incompetence: At a training for addiction counselors, a white man and a Black woman take on opposite roles and begin to argue constantly, disrupting the group; the white man denies the impact of race and criticizes the training, while the Black woman defends the training and criticizes him. But as Wells demonstrates, when looking at the group as a whole system, it becomes clear that all group members have a stake in the conflict and are unconsciously invested in perpetuating it. To resolve the problem, with its painful racial overtones, the whole group needs to change its behavior, and Wells shows us how to do just that with an effective method of group-level intervention. In short, everyone in the group needs to begin owning their feelings. In processing the enactment, it emerges that other group members also have strong emotional reactions to the training and the discussions about race. But as long as they remain silent, the two most vocal members can be scapegoated as the source of trouble.

In a political moment where any sort of conversation about identity is under attack, it's hard to overstate how refreshing and healing it felt to encounter this radical openness. It felt like freedom.

When I first encountered the Wells chapter, I felt a sense of wonder mixed with grief. We have had an effective psychoanalytic approach for resolving racial enactments available to us since the 1980s, but here we are in 2025, still struggling to take it up and put it to use. Clearly there is resistance to engaging with these technologies, but there may also be a marketing problem: Practitioners of the GRC method have not always known how to explain its usefulness to other fields that might truly benefit.

THE GROUP AS A WHOLE

The group-as-a-whole approach that Wells used to resolve the conflict is an essential part of the GRC experience: Behaviors are seen less as a function of the individual and more as an expression on behalf of the entire group. Through the mechanism of projection, the group unconsciously attempts to disown feelings that are too painful to hold, instead ascribing them to an individual member or members. When an individual member has a valence for what is being projected, they may receive it, and then the projection "sticks" and becomes projective identification—that is, an individual becomes what the group projects. Analytic clinicians who are familiar with these processes in the consulting room may find that they are significantly more intense in a group, where the displaced feelings of multiple people are projected into one psyche. Yet the theory also offers a way to depersonalize acting-out behaviors and reduce shame so that more work can happen. For instance, if one person expresses rage in a GRC, they are likely to be seen as holding anger for the whole group—an overwhelming experience for anyone—rather than as a problematic individual.

The mental muscle behind this approach grew stronger for me as I flexed it repeatedly over the weekend of the conference. Like the Magic Eye books from my childhood, group enactments require careful appraisal to be seen in all their complexity. At first we may only see the individual who lost their temper or said something offensive, and we may rush to pathologize them. But if we look again through the group-as-a-whole lens, another picture slowly comes into focus: an interdependent system that has its own "mind," where individuals are unconsciously recruited to act on behalf of the group.

I wonder what our psychoanalytic institutes might look like if more of us participated in GRCs and learned to think in this way. What kind of uncomfortable truths could we then take up and work with, that for now still feel too scary to touch as a group? Maggie Doherty noted that in her role as a journalist writing about psychoanalysis, some who were opposed to APsA's racial justice work refused to go on the record, for fear of being labeled as racist. It appears that as a system, American psychoanalysis is not yet ready to have authentic conversations about race because individuals fear they will not be safe. This is not surprising given the real challenges of such dialogues, but what do we lose by not having them at all?

The problem is twofold: Like many American professions, psychoanalysis has a serious lack of racial diversity in its ranks due to a history of systemic discrimination. But more perniciously, psychoanalysis also has a well-documented culture of not allowing the topic of race in the consulting room, where it could be integral to treatment. Many BIPOC analysts have reported that when they brought up racism in their personal treatment, their feelings about it were invalidated and instead ascribed to "universal" things like birth order. We'll never know how many promising BIPOC clinicians left the field because a core part of their experience was not welcomed or seen as worthy of analytic inquiry.

Our success in diversifying our profession—and treating our diverse clients—will depend on our ability to change this culture. I recognize there are still some analysts who rigidly adhere to the idea that talking about race and identity is inherently

Perhaps we could forgo the fleeting pleasure of treating someone like a pariah and uniting against them when they say something uncomfortable. Instead, we might say: This time it was you, but next time it will be me who steps into the mess. It doesn't matter who stepped in it; let's talk about it.

nonpsychoanalytic; perhaps no amount of emotional processing will change their minds. Yet I know there are also many in our community who recognize the importance of the social turn but avoid it because of the painful feelings it evokes. Like the white members of my small group in the GRC, they are angry at having to talk about race and scared of being shamed. Using the technology of group-level analysis, can we make space for their anger while still holding them accountable to the task of creating a future for psychoanalysis that includes everyone?

Another example from the conference may help to illustrate the point. During a large group session, a Black member pointed out that the dark-skinned people were all sitting on the outer edge of the room and wondered why no one else had named it. A few minutes later, a straight white male member expanded on the Black member's observation by stating, "the group wants to kick out the people of color and the queers."

This was unquestionably a bold and provocative statement—but it expressed something very real in the group that needed to be addressed. "I'm glad someone said it out loud," responded the Black member who had first observed the racialized seating arrangement.

Of course, it was inevitable that some members would hear the white man's statement through the individual lens, as an expression of his personal wishes, and turn against him. Yet, using the group-as-a-whole perspective, we could instead see it as a courageous statement that helped the group address something that was already happening. Since he took a risk and named it, we were able to work with it.

GROUP RELATIONS IN PSYCHOANALYTIC INSTITUTES

Imagine what might happen if someone made the same observation in a meeting of their psychoanalytic institute. Would others be able to take it in as a factual statement about the group, or would they succumb to the temptation to see it as an individual problem and shun the person who spoke? There is ample evidence that psychoanalysis—as a group—really does want to kick out the people of color. And as we have seen, it is hard to talk about all this without things going off the rails. But if we don't talk about unconscious racism, it will just continue to happen. My intention is not to offer any cover to people who make offensive comments to cause harm, but rather to express support for continuing the conversation, even when it's hard. Sometimes that means a willingness to hear out people we disagree with, including those who openly express their difficult feelings about the task—feelings like anger and fear. They are not wrong; it is indeed difficult.

Consider a hypothetical example: A white analyst publicly states her fear that talking about race will be damaging for her institute. A likely response from other members would be to dismiss her as a conservative or racist who is an obstacle to making progress, but as any seasoned GRC member will tell you, that would miss some essential truths. One, she is speaking on behalf of the system and she is not the only one who feels that way, so shunning her will not solve anything. She is expressing feelings that will keep showing up in the whole group's behavior until they are heard and worked through. Two, the fact that she was elected by the system to express this idea tells us nothing about her true beliefs.

This point is worth emphasizing, because we appear to be in a moment where a major barrier to the growth of psychoanalysis is white people's fears. Specifically, fears of being publicly shamed and called racist if they voice any discomfort whatsoever with the process—as if participating in unconscious racism were a stain on one's character. The truth is that we are all participants in unconscious systems of domination and oppression. It is not shocking or scandalous when we are caught acting out those systems; it is inevitable. Our ultimate ability to break out of this painful cycle lies in our willingness to recognize and process such moments.

What would it look like if psychoanalytic clinicians had a practice of normalizing the processing of racial enactments in our institutes? Again, I am not referring to avowed racists, but to the more common scenario of well-intentioned individuals who oppose racism and yet do it anyway. Perhaps we could forgo the fleeting pleasure of treating someone like a pariah and uniting against them when they say something uncomfortable. Instead, we might say: This time it was you, but next time it will be me who steps into the mess. It doesn't matter who stepped in it; let's talk about it. Perhaps that would make people less anxious about voicing their feelings, and in turn, lower their resistance to the task at hand.

As I wrapped up the weekend of the conference, my primary feelings were gratitude and love: that this group of courageous individuals had just spent 30 hours together, wrestling with the study of deeply painful realities, and trying to imagine how to change the world. My time at the GRC persuaded me that there is a way forward for American psychoanalysis to navigate the social turn, using well-established theories and interventions that already exist. Notably, in its section on racial enactments, the Holmes Commission Report recommended that group process become a formal part of psychoanalytic education, an idea which I wholeheartedly support. Using these technologies requires us to let down some of our defenses and feel things we would rather not. This work is incredibly difficult, but as psychoanalytic clinicians we already know quite a bit about looking at painful realities. We are well-positioned to face this challenge. ■

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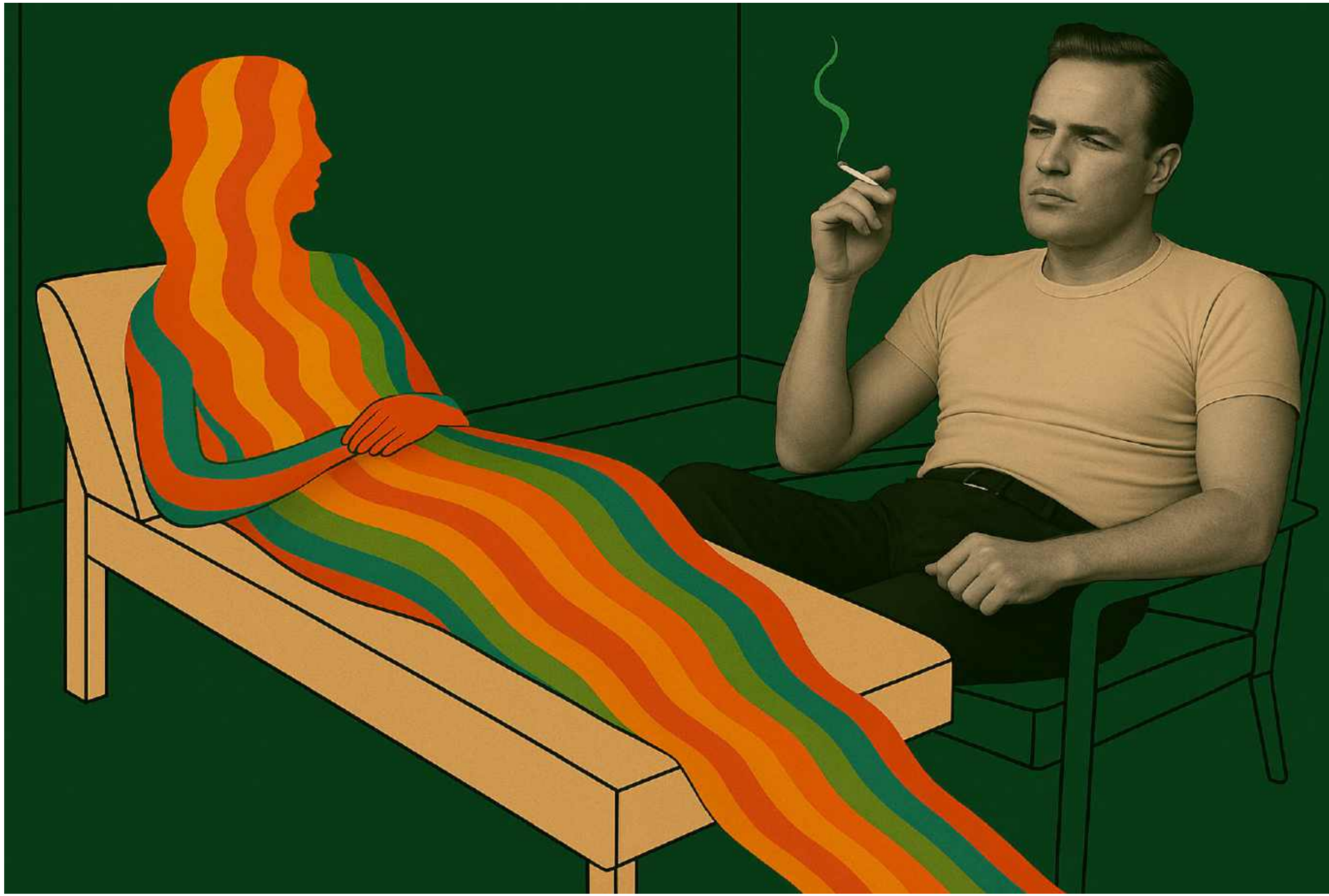
Listening Like Lives Depend On It

Are psychoanalysts method actors?

BY ADAM BLUM

"I HAVE HAD the good fortune of acting with some truly great actors," Robin Weigert told *Vanity Fair*, "and what you feel … is that they are listening to you as if their lives depended on it—because in a sense, they do." At stake is not the actor's literal survival but the life of the scene and the actor's own sense of aliveness within it, which depend on that depth of listening. In psychoanalysis, we depend on a similar intensity of attention, though we rarely acknowledge our closeness to the craft of actors. Both professions share the uncanny challenge of listening so intently that another person—whether a patient or a character—emerges.



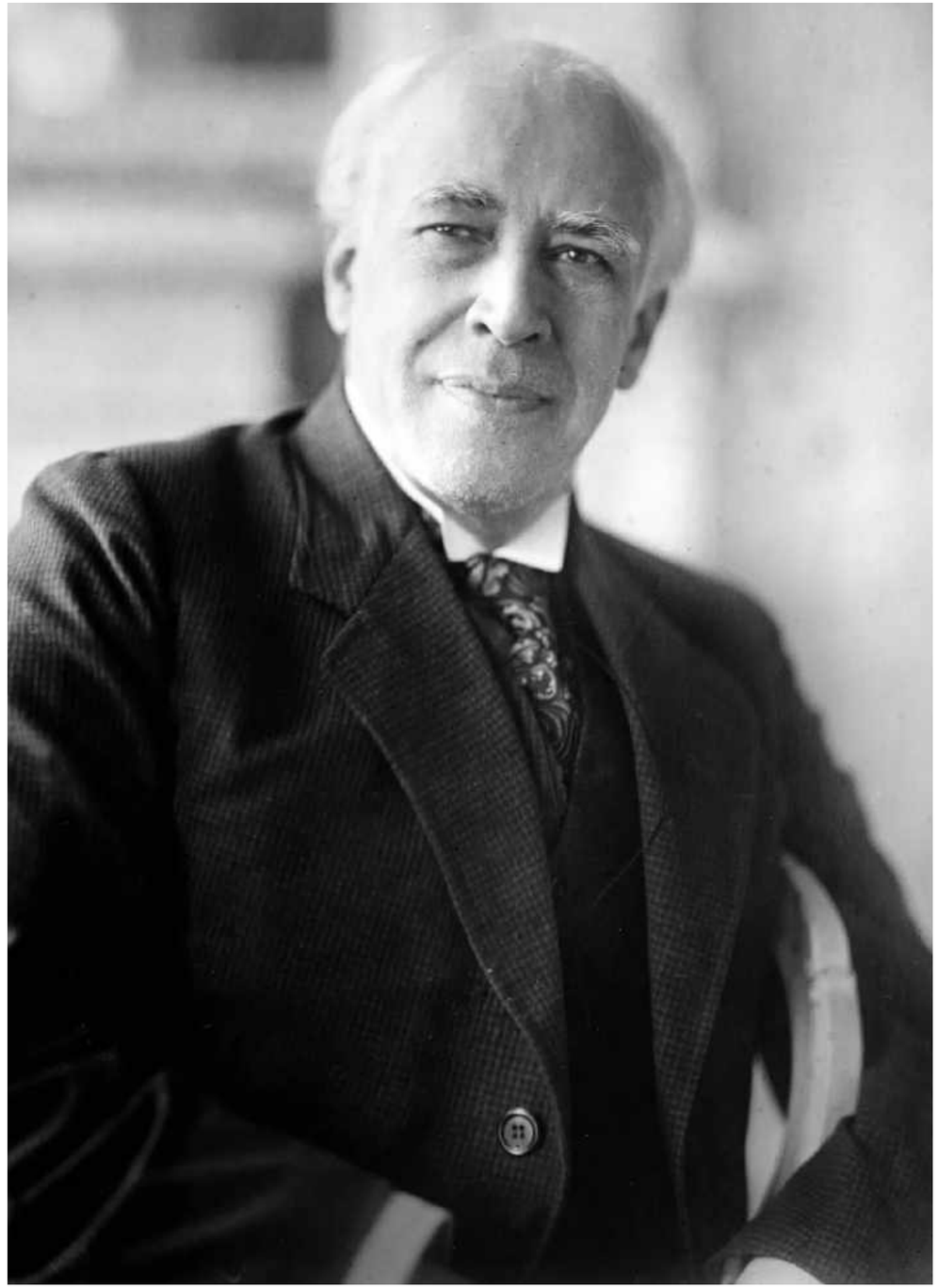
Both actor Robin Weigert and author Isaac Butler have called Marlon Brando the greatest actor of all time. How is psychotherapy like acting?

This is the challenge Weigert, an Emmy-nominated TV and film actress known for her roles in *Deadwood* and *Sons of Anarchy,* begins to address in her evocative essay "Listening into Being," in which she suggests that listening is an inherently creative act—irreducibly selective, the selection guided by a highly subjective form of perception, a hopefully well-nourished capacity for attention. She calls the essay, published in *Psychoanalytic Inquiry* in 2023, an "invitation" to analysts to contemplate the resonance between our professional disciplines. This invitation—which she later calls a "series of overtures," that musically inflected term from the Latin *apertura,* an aperture, a kind of opening—is to contemplate our respective modes of listening others into being.

When Jean Laplanche remarked, almost in passing, that a psychoanalyst was really an "art critic," he was pointing to something hidden in plain sight: that an aesthetic sensibility governs not only what the analyst says but, even more crucially, what she hears—what touches her, what inspires a response, what manages to reach her in the hourly sea of material. Weigert's actor, unlike Laplanche's analyst, is anything but a critic; she suggests that the actor's listening is not evaluative but "constructive," as free as possible from preexisting criteria that would constrict one's listening. "Constructive listening," she writes, "motored by a blend of compassion and curiosity, attends rather than evaluates." Much as Freud and Bion advocated relinquishing preexisting biases in order to attend freely to the patient's material, Weigert advocates a vitalizing practice for entering a provisional state formed entirely by the task before us and the partner with whom we attend to it.

In the zone of this practice, listening becomes a kind of primordial attunement—something we depend on to feel

"The substance of psychoanalytic work, like the powerful forces at play in the dramatic arts, is inherently unstable, uncertain, unwieldy; so without some method, some technique, some discipline to guide its practitioners, the demands of the action can overwhelm the integrity of the actors."



Konstantin-Stanislavsky, c1925, APIC, Hulton Archive/Getty Images

“Method [acting] and the psychoanalytic method flourished side by side, products of a shared historical urgency to find truth not by control, but through feeling, receptivity, and the courage to improvise.”

real, speaker and listener alike. What’s at stake is not mere understanding but existential coherence: Without being met by another’s attention, the character is left hovering at the brink of nonbeing. Accordingly, for Weigert, this mode of listening is a “visceral, appetite-driven project of manifestation.” Only through constructive (nonevaluative), impassioned listening do actors become their characters.

Of course, this form of investment is also constitutive of the clinical process. And though she practices her own listening on film, as opposed to behind the couch, Weigert is no stranger to the world of shrinks—and not just because she has played them on TV. Robin’s grandmother, Edith Weigert, was a prominent psychoanalyst in Washington, DC, as well as a writer; her son, Robin’s father, was also a psychoanalyst who convened symposia at their institute, inviting creative types to explore parallels between their disciplines. Like her grandmother and father before her, Robin is drawn to that threshold between our two disciplines, giving us an opportunity to form an invitation of our own—an overture, an aperture, an opening.

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In the second-ever volume of the *Journal of the American Psychoanalytic Association,* Edith Weigert observed that “psychoanalytic science has grown out of an art,” a technique “built on a set of rules and suggestions for practical procedures which cannot in the least cover the almost infinite variety of therapeutic situations arising in analysis.” The artist-analyst, she continues, accommodates this range only by using the unconscious—what Freud famously likened to a “receiving organ,” one that functions as variably as the patients it receives and the analysts who receive them.

This sensibility—that technique must remain alive, flexible, and governed by aesthetic intuition—finds a striking parallel in Isaac Butler’s *The Method: How the Twentieth Century Learned To Act,* a sweeping history of the style of acting that began with Stanislavsky in turn-of-the-century Russia and became ubiquitous on stage and screen during its mid-century New York heyday—a heyday it shared, of course, with psychoanalysis, the same period in which Edith Weigert practiced and wrote. It was in the mid-century theater world of New York that Russian émigrés and their students conducted a series of experiments in performance that would eventually culminate in the infamous acting technique, rooted in emotional truth drawn from personal memory and lived experience. This “Method” marked a departure from the more “symbolic” tradition of amplifying and telegraphing discrete emotions that had dominated the stages of Europe and America. Born in the same cultural moment and animated by similar convictions about inner life, presence, and emotional truth, the Method and the psychoanalytic method flourished side by side, products of a shared historical urgency to find truth not by control, but through feeling, receptivity, and the courage to improvise.

The resonance between our two traditions—analytic and theatrical—has not gone unnoticed, especially by those within the acting world; one of the Method’s figureheads, Lee Strasberg, once described it as “very near the psychoanalytic method.” As Butler notes, “one of the most revolutionary ideas of the ‘system’ was that an actor’s inner life could be trained.” The common element between the two methods seems to be a form of surrender to one’s unformed, emerging self to guide one’s conduct—indeed, to conduct oneself precisely according to the movements of one’s unconscious, relying on it, as we do through countertransference, to let us receive the patient, and to reach back toward them in turn.

But neither actors nor analysts ever surrender themselves entirely to the movements of feeling. They are bound not only by the material before them—the analyst by the patient, the actor by the script—but also by some form of, well, *method,* though one whose specifics are notoriously elusive, around which no pure consensus has ever truly formed. The term “psychoanalytic method,” first formalized by Freud, was less a blueprint than a provocation—an invitation to listen and interpret without fixed rules, continually reimagined by every generation, every analyst, that claimed it.

The substance of psychoanalytic work, like the powerful forces at play in the dramatic arts, is inherently unstable, uncertain, unwieldy; so without some method, some technique, some discipline to guide its practitioners, the demands of the action can overwhelm the integrity of the actors. “The profession of acting,” Strasberg wrote,

> the basic art of acting, is a monstrous thing because it is done with the same flesh-and-blood muscles with which you perform ordinary deeds, real deeds. The body with which you make real love is the same body with which you make fictitious love with someone you don’t like … in no other art do you have this monstrous thing.

Robin Weigert helps us understand that what safeguards the integrity of creative emergence under the threat of monstrous overwhelm, the madness for which method is urgently necessary, rests entirely on the constructive copresence of another person. It’s fitting, then, that both she and Butler turn to the same figure, Marlon Brando (whom both suggest is the greatest actor of all time), as an emblem of this vital partnering. Weigert recalls a famous episode of Brando slapping a fellow actor while filming *The Godfather*—“not in order to gift his fellow actor with a moment of on-screen truth,” she explains, “but to insure that his fellow actor’s wandering attention did not compromise the truth of his own character’s existence.”

Like his life depended on it, Brando is not only listening but demanding a form of attention through a form of *action.* Sometimes one has to do something in order to be able to feel something; Stanislavski always insisted (contra Strasberg) that “one cannot feel and then do the problem—first act the problem for the physical action and then you will be able to feel.” Where Strasberg emphasized drawing on personal emotional memory, Stanislavski believed the key was doing—that feeling would follow from action (*Action!*), not precede it.

It’s a principle that resonates uneasily within psychoanalysis, where “acting” has long been treated with suspicion—whether in the discouragement of acting-out or the wary curiosity surrounding enactment, that double-edged term for when unconscious dynamics leap from speech into scene.

I find myself turning to one of Weigert’s own performances, perhaps her most vivid appearance in the consulting room (if not quite behind the couch), as a zero-nonsense therapist to Nicole Kidman’s character, who is trapped in a violent and dangerous marriage, in the first season of HBO’s *Big Little Lies*. Weigert, as therapist, becomes increasingly forceful in her interventions in an attempt to penetrate an atmosphere of denial, dissociation, and profound terror. As I watched the scene during its premiere (years before reading her essay), I remember wondering whether this was proper technique, true psychoanalytic method; or, more specifically, how many of my psychoanalytic colleagues actually practiced in this more active, passionate mode, a stark

Robin Weigert, whose father and grandmother were psychoanalysts, played Calamnity Jane on *Deadwood* (2004–2006) (HBO).

contrast with the caricature of reserve and neutrality—perhaps a straw man—that continues to loom large in our field despite numerous campaigns to dismantle it.

But perhaps this caricature persists precisely because of an underlying discomfort with what a more passionate clinical stance might require. If actors have something to show us about the power of listening, of trusting an aesthetically shaped form of attention and receptivity to form us into the "scene partners" our patients need us to be, do they also have something to show us about the *suffering* involved in this passionate process (suffering and passion having a common origin in *pathos*), the doing behind feeling, the lengths we may go to summoning a patient into being, to bear the occasional agony of this birth? Pulitzer-winning playwright Tony Kushner has suggested that an audience needs to see the actor suffer. Might the same be true of what patients need in analysis—a movable scene partner—in diametric opposition to their need for the analyst to be strong, resilient, indestructible? To see the analyst destroyed while simultaneously—paradoxically, as Winnicott formulated—surviving this destruction?

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The greatest synchronicity in discovering Robin Weigert's essay (other than having just finished Butler's book) was realizing she had already been present in my mind through my work—speaking immortal words from Kushner's 1991 masterpiece *Angels In America*, filmed for HBO in 2004. I find myself thinking of this scene when I am reaching for images or thick descriptions of grief and loss. Harper, another character trapped in a very different kind of destructive marriage (played by Mary Louise-Parker), visits the Mormon Visitors' Center and addresses a female figure, a mother, in a diorama of Mormon settlers. "Was it a hard thing, crossing the prairies?" she asks the figure, who now springs to life. "You ain't stupid," the Mormon Mother (played by Weigert) replies. "So don't ask stupid. Ask something for real."

HARPER *(A beat, then):* In your experience of the world. How do people change?

MORMON MOTHER: Well it has something to do with God so it's not very nice.

God splits the skin with a jagged thumbnail from throat to belly and then plunges a huge filthy hand in, he grabs hold of your bloody tubes and they slip to evade his grasp but he squeezes hard, he *insists*, he pulls and pulls till all your innards are yanked out and the pain! We can't even talk about that. And then he stuffs them back, dirty, tangled and torn. It's up to you to do the stitching.

HARPER: And then get up. And walk around.

MORMON MOTHER: Just mangled guts pretending.

HARPER: That's how people change.

If change, like Kushner (like Bion) suggests is inherently catastrophic, then we rely upon artists to show us how to suffer the psychophysical violence of life's hardships into viable ways of being human. In the most poignant moment of her essay, Weigert reflects on her analyst-father's chronic depression as "a form of sadness that affects the artist without an art form." Drawing on her grandmother's inspiration, and her father's suffering, Robin invites analysts to become the artists their patients need them to be, prompting us to recognize in actors a practice essential to our own craft, to imagine psychoanalysis as an art form that listens the artist within the patient into being. (The appreciation between actors and analysts may in fact be mutual, as Butler recounts; responding to James Dean's entreaties for acting advice, Marlon Brando told him to go see an analyst.)

Weigert, on and off the soundstage, reminds us that becoming—whether in character or in analysis—is not a clean process. It is stitched from pain, pulled into ever-evolving forms through attuned accompaniment, and animated by the hope that someone is paying close enough attention to let us become ourselves—to experience what Winnicott once called the feeling of real, the birthright of being listened into being. ■

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Illustration by Austin Hughes

PSYCHEDELICS AND PSYCHOANALYSIS

A conversation with John Burton

Series: Psychoanalytic Voices on the Issues of Our Time

STORY AND PHOTOGRAPHY BY TRACY SIDESINGER

PSYCHEDELICS ARE everywhere today. Whether it's mushrooms being microdosed for creative work, ketamine on the street, or ritualized ayahuasca retreats in Peru, these substances—first popularized, and then demonized, during the 1960s and 70s—are indeed having a renaissance. They're in the research lab too, now a multibillion-dollar industry primarily looking to address mental health issues like chronic depression and PTSD that are minimally responsive to other treatments.

Psychedelics and psychoanalysis have a kinship: Both have the potential to loosen a person's grip on established patterns of thought and behavior. And their pairing may have far-ranging implications for psychological treatment.

What follows is the first in an ongoing series of interviews with psychoanalysts, psychodynamic therapists, and others about issues of relevance to our times. To discuss psychedelics and their relationship with psychoanalysis, I sat down with John Burton, MD, in his New York City office in Gramercy. Burton is a psychiatrist and psychoanalyst who incorporates Ketamine-Assisted Psychotherapy (KAP) into his practice.

What was your path into psychiatry?

You know, when I went to college, I was sure of one thing, that I would not go to medical school. When I went to medical school, I was sure of one thing, that I wanted to be a "real doctor," not a psychiatrist. It sounds very conflicted of me, and it was. But, as psychoanalysts, we trust there is a through line to these kinds of conflicts and indecisions.

I was pretty disillusioned by how medicine was actually practiced in a tertiary medical care center, which was very biological and mechanistic. I was working with brilliant people, but patients were kind of housed in the hospital waiting for their labs, no one was really seeing them. Psychiatry itself was in the "Decade of the Brain," believing that if we can understand the functioning of the brain as well as possible then we can give a person the right biological treatment and we don't need to know anything else. People were just bodies that either worked or didn't. There was little consideration of the human experience that was in those bodies.

Except for the dynamically oriented psychiatrists. It seemed to me that they had a kind of x-ray vision to see things going on that no one else was seeing. Understanding people on that level was absolutely necessary to be able to help and heal them. Otherwise, to me anyway, what was the point of getting healed physically if your psyche was miserable? My friends and classmates would probably disagree with me, but that's how I felt. I was always drawn to what was underneath, holding uncertainty, not putting things in boxes. I didn't want to simplify and reduce people. That's what drew me to psychoanalysis, and that's what drew me to working with psychedelics.

How long have you been working with psychedelics?

When I first read Michael Pollan's 2015 *New Yorker* article on the psychiatric research on psychedelics going on at the time, I recognized a couple people I trained with and thought, "Wow, I did not see this coming!" I read *How to Change Your Mind* and continued to look for information and training, especially during Covid when I had the chance to sit still and learn more. I got excited and realized that this is the same thing I've been looking for, the appreciation of what lies underneath, that drew me to psychiatry and then to psychoanalysis. Researchers were working in a model that is neurofunctionally based, but coming back to defense mechanisms and repressed material. Even though most of them are not psychoanalysts, I saw an overlap for the first time between biological psychiatry and psychoanalytic thinking in ways that were exciting and not conflictual. On top of that, it also added something to my psychoanalytic framework: mystery and awe, joy and wonder. I started to think, what is the role of that in psychological health? Early on, Freud, Reich, and Jung were radicals. They were disruptors. And that's what psychedelics have the potential to do in our field.

You work mostly with ketamine, is that right? How do you decide when someone would benefit from ketamine treatment instead of or in addition to something else?

That's right. Two years ago I completed training in KAP and I have been doing ketamine sessions with psychotherapy patients since then. Ketamine is what is legal and available for use. On average, I arrange for a KAP session in my office a couple of times a month at the most.

Ketamine is used for numerous psychiatric indications, such as PTSD and treatment resistant depression, and is also being actively studied as an intervention for addiction and other psychiatric diagnoses. In my practice, as a psychoanalytically oriented psychiatrist, I am using ketamine solely within the context of psychodynamic psychotherapy and psychoanalysis. If I felt that someone might benefit from ketamine treatment for depression primarily, I would refer them to an infusion clinic that provides ketamine using the schedule and dosing that has been developed to alleviate symptoms of depression.

In contrast, I use ketamine exclusively with patients who have ongoing therapeutic relationships with me, where we see the potential for a KAP session to move the process forward in a way that augments the psychotherapy itself. Some patients have initiated the consideration of a KAP session themselves. Sometimes I will suggest it to patients. It seems to be particularly helpful for patients who find themselves caught in a cycle of rumination, rigid behaviors, or maladaptive defenses that continue despite thorough analysis and insight. Since KAP is an experiential intervention, it often allows for breakthroughs that do not come from the verbal, intellectual work of psychotherapy. It is in many ways analogous to the use of the couch which fosters free association. The couch, by the way, can be thought of as a "nonordinary state of consciousness" itself.

You are also trained in yoga and integrative psychiatry. It seems like you've gone in search of various kinds of treatment. Is there an implicit caution here, as in, "Ketamine can do really useful things but it's not the only thing?"

It's definitely not the only thing. What I do want to emphasize is that there's something uniquely powerful about psychedelics in a psychoanalytic context with a therapeutic alliance and the ability to understand transference and countertransference as part of the work and meaning making as part of that. So certainly other things are just useful for people to do, like meditation.

And with some patients, many in fact, we have considered it and decided not to do a KAP session. I feel like this

happens especially with patients who are using the couch in a more traditional four-times-a-week analysis. We have agreed very clearly that ketamine was not something they needed at the time and that it would actually be disruptive to the ongoing deep analytic work that they were doing. The more powerful experiences I have had were with patients who felt like they kept coming to these insights of awareness but there was something holding them back. They were not able to get a handle on it or not able to translate it into meaningful life change in their relationships or ways of doing things. Psychedelics by definition disrupt. As Stan Grof referred to them, they're "nonspecific amplifiers." I think of them as nonspecific disruptors to the ego. To show you what your perception is like without your ego, or what neuropsychologists call the "Default Mode Network."

In your recent coauthored commentary in *Frontiers in Psychology*, you challenge the belief that CBT should be the default framework for doing psychedelic therapy. You point out that CBT does not address the relationship between conscious and unconscious states, whereas this relationship is fundamental to psychoanalysis.

My radical thought is this: How can you effectively work with these substances—with all respect to Indigenous and shamanic traditions which are working in a different framework, more ecologically, or even cosmologically oriented—without thinking psychoanalytically? How can you work with people going through nonordinary states of consciousness and what comes up with that unless you're doing it in the context of a therapeutic alliance? You have to understand what transference and countertransference are. We as analysts have a way of observing the patient's feelings and our feelings coming up and making use of that. Without that framework a lot of potential is being missed and potential harm can be caused. As psychoanalysts we're experts on holding uncertainty and looking for meaning at the same time. It's not that people with a more CBT approach or ACT or IFS—all of which are very popular in the psychedelic space—are not looking for meaning. It's that the way psychoanalysis constructs meaning and understands repressed content especially is unique and, I think, uniquely needed in working with psychedelics.

From an ego psychology perspective, there is a respect for mechanisms of defense that ward off fantasies and feelings. We actually need our ego. The problem is not the ego itself but the over-controllingness of the ego. One of the things that I feel is most helpful in doing psychedelic work is the preparation. As soon as you start talking about doing psychedelics, we're already doing psychedelic psychotherapy because it's stirring up meaning. I'm not just preparing someone safely for their journey, I'm seeing the transferences that are happening to the experience, to the medication, what meaning, hopes, and fantasies for cure are coming up. We're particularly attuned to hearing those things in a session, which makes the preparation phase of psychedelic therapy extremely rich and useful. I've had preparation phases for patients who never went on to have the ketamine session because they decided they didn't need

it, but it stirred up our psychoanalytic process in a way that can only be considered a success. But the other piece is in the integration. After psychedelic experience, what do you do? In psychedelic work you watch your ego disappear or retreat into the background but then when you come out of the journey you can see it much more clearly coming back online, you see your ego reconstructing itself.

And you need an ego, you need to come back to it.

You need an ego, but more than that you can see the automaticity of it. That's what I'm trying to emphasize. Because however much regression you get on the couch, you just don't get the same degree of dissolution of the ego that you do on a psychedelic journey. But then as it reconstitutes itself you see it. Yes you need it, but seeing what it's doing to you that you don't need creates a kind of insight and self-awareness that is extremely helpful.

In addition to being a legal treatment, ketamine is also a pretty popular street drug. What's the difference between using it in a guided treatment setting and recreationally?

It's really important to acknowledge that to do due diligence, we need to talk about the risks and benefits of the medicine. But we also have to talk about the real power it has. The misuse of ketamine is a testament to the power it has and why it needs to be thought of so carefully. Now that I have sort of a reputation of doing ketamine psychotherapy I've actually been referred some of the worst cases of ketamine abuse I've ever imagined before this, and I'm not an addiction psychiatrist. But, as a psychoanalyst with training in ketamine, I was uniquely positioned to talk to these individuals about their experience and help them feel understood in what they were trying to achieve in their street use. Sadly, for people who have already been abusing ketamine, it would definitely not be the right treatment for them. I have become personally shocked and impressed at how dangerous it can be in the wrong set and setting. That's a psychedelic terminology, "set and setting," but it's also very analytic. It addresses the two most important factors that make the difference between a profound and therapeutic experience and a damaging one.

Would you say that there is a wrong set and setting, a wrong intention or frame when using psychedelics?

Well, there are many ways set and setting can be not right. Not being safe is the first. There are many ways of being unsafe, and being physically unsafe is only one of them. I would say the larger concern is about the interpersonal dimension and social safety. If you have a psychedelic experience in a group of people who are not prepared to tolerate and hold for you what comes up, that is unsafe. You're going to be traumatized by that. I would say that more than the medical issues with

"SADLY, FOR PEOPLE WHO HAVE ALREADY BEEN ABUSING KETAMINE, IT WOULD DEFINITELY NOT BE THE RIGHT TREATMENT FOR THEM. I HAVE BECOME PERSONALLY SHOCKED AND IMPRESSED AT HOW DANGEROUS IT CAN BE IN THE WRONG SET AND SETTING."

the abuse of ketamine—and there are real medical issues—the possibility of a psychedelic experience being traumatic because of the setting is the biggest danger.

But the positive impacts may also span beyond personal transformation. I've heard it suggested that psychedelic states may decenter Western, psychoanalytic notions of self and reality. Since you have started working with psychedelics, how has your view of the psychoanalytic project changed? Do you think about the psyche differently, or the goal of your work?

There has definitely been an evolution in my approach to psychoanalytic work. One aspect in particular has been the role that wonder, awe, and what are often called mystical experiences have in healthy psychological functioning. I always felt that psychoanalysis offered a way to see beneath, or beyond, the surface manifestations of psychological suffering into the universal human attempts to make sense and adapt to our world. At its best, psychoanalysis brings a kind of humility to the work. Often, however, psychoanalysis falls prey to the arrogance of certainty that occurs in many areas of medicine and psychology. For me, psychedelics have brought back to the forefront of my psychoanalytic work the role of mystery and surprise that brought me to the field to begin with. ■

In Psychoanalytic Voices on the Issues of Our Time, ***Tracy Sidesinger, PsyD,*** *a clinical psychologist practicing in Brooklyn, interviews analysts, psychodynamic therapists, and others on wide-ranging topics that address the struggles and desires of contemporary human life. This interview has been edited and condensed.*

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The Walking Drive:

Bringing psychoanalysis to walking therapy

BY LILY MEYERSOHN

Illustrations by Tati Nguyễn

> The Tunisian-French psychoanalyst Gérard Haddad suggests that psychoanalysis needs to name a drive in addition to the oral, anal, and genital. He termed it *pulsion viatorique* (from Latin *viator,* meaning *traveler)*—the walking or ambulatory drive. Before we are *speaking* beings, we are *walking* beings, notes Haddad. The Oedipus story begins with a father maiming his son's feet so that he cannot walk; the very name "Oedipus" means "swollen foot."
>
> —LUEPNITZ AND DEBIAK (2024)

MORNING, SO the fog still hadn't lifted for the day. Two men, looking much like a father and his grown-up son, walk up the hill. They each face forward, engaging intently in conversation. Do they have a destination in mind? Only they know. If the fog were to lift, then the pair's view from the top of the hill, of the city and the bay, would be magnificent.

A rising number of psychotherapists with disparate training in social work, mental health counseling, and psychology are finding themselves in scenes like this one—albeit in a variety of geographic settings. To enhance the therapeutic alliance, to foster connection with the social and natural world, to unsettle power dynamics at play in traditional therapy, and to ameliorate some of the problems with seated therapy (e.g., physical pain), therapists are increasingly turning to walking therapy. Their patients include some of the millions who moved to telehealth treatment around the time of the Covid-19 pandemic—patients now seeking treatment that is not only in person but in motion.

This summer, I spoke with more than a dozen therapists who have implemented walking into their therapy practices, either on an ad hoc, as needed basis or as one of the core elements of their work. Therapists are walking with their patients in Central Park in Manhattan and Prospect Park in Brooklyn, in the suburbs surrounding DC, across rural hamlets in the UK, on the beach in Los Angeles County. Many of these clinicians are passionate about movement and energized by the work they are doing outside with patients. But the psychotherapeutic community still lacks a cohesive framework to think about what walking offers the therapeutic dyad. Psychoanalysis can contribute to that framework, helping us think about how and why we might want to get out of the chair and walk.

THE CONTAINER

Walking therapists come from a range of backgrounds, but they tend to work in private practice, live in more suburban and rural settings with greater access to the outdoors, and market themselves to physically active patients who are already familiar with walking or running for pleasure. By and large,

they do not work psychodynamically, skewing instead toward so-called evidence-based approaches.

But walking therapy need not be limited to the patients of non-depth therapists. Walking is an accessible approach that can treat an array of patients, even those experiencing mild or moderate chronic pain. Indeed, for some it can directly alleviate pain symptoms.

Psychoanalytic and psychodynamic clinicians remain curious but hesitant about working in this way—suggesting, perhaps, an intrapsychic conflict. Psychoanalytic constraints, or "rules," create anxiety and keep therapists sitting down. Aleksandra Wagner, a psychoanalyst and professor emerita at the New School, suggests that analysts usually start their thinking about walking therapy from a point of repression: from the assumption that we should not be doing it. These limitations are imposed from the very first phrases that a therapist so often utters to a patient: "Please take a seat."

What if the psychotherapeutic space were not handed over intact by the therapist but rather created as we walked? In her critique of the psychoanalytic concept of the containing space, Martyna Chrzescijanska suggests that the therapeutic space looks less like Bion's theory of the container/contained and more like the outer landscape and the patient's associations to it. Though psychoanalytic language—including the holding environment and the container/contained—tends to reference the mother's relationship with her infant and the womb-space she provides, the field of psychogeography helps rework the concept of containment by thinking about how the quality of open attention works in the outdoors. Psychogeography, after all, originated in the 1950s in the ideal of the aimless walker, the flâneur, walking without knowing where they are going.

For Lara Just, who provides outdoor therapy in the UK, "paying attention" works differently outside than it does inside. Outside, the natural world becomes a co-container. The landscape situates patients within a more expansive context of relationships in the social and natural world. This transforms Just's ability to hold the patient, helping her feel more expansive and less isolated as a practitioner. Patient, therapist, and nature all play a key role in the relationship. Rather than attempting to "extract the peace and calm of nature," the dyad expands to a triad that respects and considers the earth. This is Just's quiet resistance to the disembodiment, distraction, and despair of our times.

DISEMBODIMENT

Psychoanalysis is no stranger to the struggle against disembodiment. Fernando Castrillon—clinical psychologist, personal and supervising analyst, and professor emeritus in the Community Mental Health Program at the California Institute of Integral Studies—has found that in recent years, more and more of the young people coming in for analysis "have a rough time speaking and instead speak through the body." These patients may have somatic complaints but have difficulty speaking about what, in particular, ails them. These treatments require preliminary work, a kind of preanalysis, to help patients begin speaking.

All too often, Castrillon and I mused, therapists, even psychoanalysts, have the same issue: They fall for the mind-body divide, the old split. When we talk about "walking therapy," therapists tend to focus on the physiological benefits of movement—improving cardiovascular fitness, for instance. But by focusing on physiology, we split body from mind.

From Berkeley, Castrillon rhapsodizes about the archeological record of the human capacity for walking: the way human anatomy and physiology—how our spines meet our skulls to enhance our balance, the location of our eyes in our face—are all set up for us to walk and run, to hunt and gather. Psychoanalysis forgets that. It represses the fact, the memory, that for hundreds of thousands of years, our capacity to think occurred in movement, via walking or running. "If we're not engaging in shared movement," Castrillon said, "how do we work through things?"

To be clear, walking in therapy doesn't mean on a treadmill inside an office. It means *walking outside, in the world, together.* There is more than physiology at work here—more than bilateral stimulation or the benefits we reap from getting our blood moving. For a Lacanian like Castrillon, an analytic treatment at its best can attend to the Real of the body—the dimension that resists symbolization and eludes meaning. But body *is* psyche. And this is a psychic process, Castrillon argues. "When a patient is walking," he says, "they are speaking." The body is being used to help the patient speak and associate.

When Noah Miska walks with private practice patients in Prospect Park, for instance, the body is brought into sharp focus, with all its heightened and clarified "implications for transference and countertransference," as psychiatrist Cathy Schen puts it. Bathroom options are limited in the park, and sometimes, someone may have to relieve themself outside. "Out in the world," Miska said, "the messiness of a body is more present." Sepideh Saremi, a psychodynamic therapist who emphasizes the relational processes at work during walking sessions, adds that "there is still plenty of transference" in walking therapy—"but I feel less intrusive as a therapist." Side by side, patients may feel less pressure to make eye contact. The therapist is not perceived to be "scanning for judgment." In some ways, then, walking represents a *return* to—rather than a departure from—the couch, since Freud did not meet his patients' gazes as they lay in his office.

EARLY ITERATIONS: FREUDIAN WALKS

As a medical doctor, Freud had extensive knowledge of the body, and he believed that physical movement facilitated insight. He did not ignore the bodies of his patients who arrived to him displaying somatic symptoms. Among the second generation of analysts, Wilhelm Reich also wrote extensively on attending to the body during analysis, and he and his followers used (at times questionable) body-focused exercises and protocols. But as psychoanalysis moved from Freud's couch to offices across Europe and the United States, what took off was his and Josef Breuer's "talking cure," not their "walking cure."

Fundamentally, the psychoanalytic method was invented for the couch, not the street or the park. Freud believed the couch facilitated the emergence of unconscious material. The couch allowed for intimacy to develop between therapist and patient without breaking Victorian-era norms around physical proximity or touch. When walking together, the therapist and patient are closer than they usually are when sitting in a room together; we can imagine them bumping shoulders, as if on a romantic evening stroll, about to stop for a drink. As the practice of psychotherapy was developed and standardized, the profession also emphasized the transference relationship and the importance of establishing boundaries between therapists and their patients—leading therapists to favor working in more "controlled" indoor settings, as counselor Stephanie Revell notes.

"Limitations are imposed from the very first phrases that a therapist so often utters to a patient: 'Please take a seat.'"

Yet this history leaves out the fact that Freud himself did walk. He walked with patients around the university in Vienna and even conducted a few walking analyses: of Max Eitingon in 1907 and of Gustav Mahler in 1910. Mahler's analysis took place in Leiden, while Freud was on holiday at a coastal resort. Freud walked with Mahler for four hours among Leiden's canals. Mahler was suffering from heart disease, in distress over his own sexual dysfunction and the pursuit of his wife, Alma, by Walter Gropius. Legend has it that the analysis was a stunning success.

VOICES OF WALKING THERAPISTS

The literature tends to credit Thaddeus Kostrubula as the first therapist to embrace and disseminate walking therapy. Kostrubala was known as "the running psychiatrist" and practiced what he called "running therapy." He found running—any pace between an ambling walk and a full run—helpful for patients dealing with a range of psychological concerns including depression, anxiety, psychosis, and addiction. As a clinician, Kostrubala felt hemmed in by the indoor setting and found its required seated positions passive and restrictive for both members of dyad. Running therapy, meanwhile, seemed to foster a more equitable relationship. Outside, the therapist was no longer in charge of the setting or all the rules. The patient could literally direct the course or path of the treatment. The approach unsettled the power differentials between therapist and patient by involving them in joint movement and shared rhythm, facing the same way and moving in the same direction.

Kostrubala's "running therapy" terminology has largely been left behind, but walking therapists still echo many of his beliefs. Jennifer Udler, a social worker and founder of Positive Strides Therapy, felt restricted in the office. In her current work, she and her patients look out for each other in the space they share outside. "It's not 'my office, my chair, my rules.'"

Many of the clinicians I spoke to first became curious about walking with patients after having positive experiences of walking, hiking, or running in their own lives—such as listening to a reticent friend who suddenly opened up on a walk, or noticing how good they felt after spending a day walking in the woods. Others came to it during a time when walking was the only thing keeping them going. Lara Just, for instance, only began walking therapy after a painful divorce, when she couldn't imagine going back to a typical office. Plus, finding clinical space was becoming prohibitively expensive in her area. Udler, meanwhile, intuitively added walking to her practice before she came upon research and a wider community already using the approach. She is now an administrator of the Facebook group "Walking, outdoor therapists," which formed seven years ago for members to offer each other clinical support and has more than 700 members.

Some of these therapists have full walking caseloads, while others have walked as more of a one-off, perhaps during the Covid-19 pandemic or in response to an episode of acute back pain. Some walk with any patients, while others specialize in a particular population—new parents, for instance, who may feel isolated at home and who often bring infants along for sessions. Over and over, I heard about patients who reached an impasse inside and only broke through after moving outside. Udler was reminded of one child patient with depression. While walking, the boy was "a different person. I did not see the depression; I saw an active kid who had a lot to tell me."

Patients value the work. Saremi finds that patients increasingly "want this type of relational practice." Based in Redondo Beach, California, she founded and currently runs Run Walk Talk, which offers a directory of walking providers and a 12-week training program in walking therapy.

And clinicians often repeat that they feel lucky to walk. While outside, they find they feel more present in their bodies. It can be uncomfortable or taboo for a therapist to consider moving outdoors for her own benefit or to center her own preferences. But Udler believes that walking "makes us better therapists … We're more alert, doing our best thinking."

After back-to-back sessions in the park, Miska feels "good in body and in spirit. Physically tired and physically well." How many workers, let alone therapists, can say that?

> "Many of the clinicians I spoke to first became curious about walking with patients after having positive experiences of walking, hiking, or running in their own lives—such as listening to a reticent friend who suddenly opened up on a walk, or noticing how good they felt after spending a day walking in the woods."

WALKING IN COMMUNITY MENTAL HEALTH

Walking doesn't always work, and Castrillon cautioned about treatment specificity. In Castrillon's own analysis, his analyst only suggested walking towards the end of the several years they spent together, when Castrillon was having difficulty, as he puts it, inventing his way off the couch. Castrillon credits walking together with his ability to end the therapy—in Lacanian terms, to get rid of the father on account of using him. Walking, he believes, was "well timed" in his analysis.

Many clinicians express concerns that walking therapy might be safer for people who are "resourced," or relatively untraumatized. But seated therapy can pose its own risks to patients with trauma, who can dissociate or else become dysregulated or overwhelmed in the indoor setting. For these patients, office walls may feel "oppressive," writes Nick Tarrant, "the closeness and expectancy of the therapist too intense." Others find that walking side by side makes the work less intimidating, thereby reducing the emotional barrier to entry.

Saremi, like Castrillon, started off in the community mental health setting, working with Iranian immigrants seeking culturally appropriate care delivered in Persian. Some of these patients were torture survivors for whom the cinderblock walls of the office, Saremi said, were a reminder of their interrogations. For some patients, making eye contact with a woman while sitting across from her in their living room during a home visit was neither culturally appropriate nor comfortable. As a patient, Saremi identified with patients like these, who struggled to get in the door for therapy. Walking therapy, on the other hand, was less intimidating.

Walking therapy can even be indicated for patients with psychotic spectrum disorders. While a closed room seems inherently containing, Aleksandra Wagner notes that for people experiencing psychosis, walking outside can be containing. According to Leston Havens, purposeful side-by-side positioning of therapist and patient can reduce a psychotic patient's paranoid and hostile projections.

In the first years of his work as a clinical psychologist, Castrillon primarily worked with patients with schizophrenia. He remembers suggesting a walk to one very quiet patient with psychosis. The patient jumped at the idea. They walked by a greenhouse nursery; the patient was "transfixed." He started talking. "The more we walked, the more he spoke," Castrillon said. The patient was able to use their shared movement, and their shared landscape, to begin articulating what he had previously been unable to articulate.

Therapists can walk with psychotic patients in many settings, of course—from inpatient hospitals to outpatient private practice. Much of the work takes place in community mental health settings, however, among clinicians who Saremi says have "done this work forever without getting credit for it." Even when institutions have not provided clear guidance or training, these workers have been "scrappy and resourceful." Noah Miska, for instance, began walking while he was a case manager for unhoused patients camping out in rural Oregon. Walking, Miska says, provided "freedom."

GLOBAL APPROACHES: ACOMPANHAMENTO TERAPÊUTICO

Other models of walking therapy exist globally. In the 1960s, as part of the psychiatric reform and antiasylum movements, clinicians in Argentina began treating chronic patients who did not adapt to traditional treatments through an ambulant clinical approach called therapeutic accompaniment, or TA. The practice spread to Brazil, first at the Pinel Clinic in Porto Alegre and then to Rio de Janeiro and São Paulo. The approach taken up in Rio was more strongly influenced by psychoanalysis than by the American community model. TA is still relatively widespread in São Paulo, especially in psychoanalytic circles, and is mainly offered as a free public service.

TA aimed to help socialize patients during the psychiatric reform movement. In the US, mental health service users experienced a similarly drastic shift in their spatial lives during the period of deinstitutionalization in the mid-20th-century, which saw the closure of numerous state-run asylums. But TA did not find intellectual or institutional roots here in the US. In Brazil, the approach has since expanded to treat a wide range of patients: the elderly, children, and people with phobias, depression, panic, autism, or schizophrenia.

Therapeutic companions (*acompanhantes terapêuticos*) accompany the patient in their daily tasks and activities. The boundaries of the practice are not limited by the room or hospital's walls. Rather than trying to draw the patient out, as it were, TA aims to immerse itself in the patient's individual universe. The "listening apparatus" of the therapy becomes the whole body and everyday life. Instead of a patient trying to *represent* their internal world, their internal world is *presented* in the physical world. Once again, in Lacanian terms, TA hews closer to the Real.

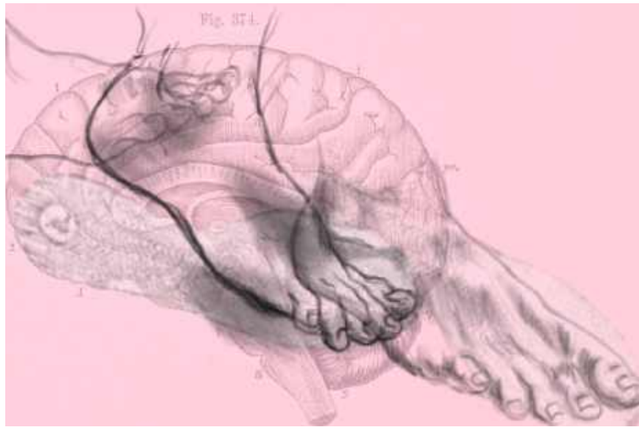
Léo Tietboehl, a psychoanalyst and psychologist based in Rio Grande do Sol who has done TA on occasion, describes how important the body is to TA. Many years ago, Tietboehl worked with a 40-year-old man with multiple disabilities who used vocalizations, but not language, to communicate. The patient, who had psychosis, was "not used to having a choice in where he went," Tietboehl said. He was rarely free from other people's gazes and had little autonomy to explore public space, having never left home without a family member's company. When they met for a session, Tietboehl would stand back to allow the patient to choose the route. Therapist and patient were able to communicate through the direction of the walk that the patient chose. The risk of interference or disruption was always high. But TA embraces that reality rather than pushing it away.

STREET THERAPY

Perhaps the closest thing to TA happening in the US, as I see it, is the street therapy provided by mobile clinic teams. In New York City, Natalie Casagran Lopez works on an intensive mobile treatment team for patients with serious mental illness, who are often experiencing psychosis, substance use, and high levels of social precarity. For the most traumatized, being inside may simply not make sense. Many are not comfortable inside, while others walk miles every day to stay warm, seek services, or alleviate boredom. In some cases, being alone with a clinician in a small space might only exacerbate trauma. Casagran Lopez describes how, "for people who have been chronically institutionalized with little living space—living in a hospital with a roommate, or incarcerated, with a cot in a room full of 50 other men," walking outside is the very thing that allows access to expansiveness in a therapeutic session or visit. The city's streets provide the holding environment.

This work requires therapists to "go with the flow of the changing environment," says Casagran Lopez. Therapists work on the patient's clock and must be sensitive and responsive to a patient's pace. Some days that might mean accompanying a participant at the mouth of a tunnel, dodging traffic as he solicits money from commuters in their cars; other days, it might mean squatting or sitting on the curb together, in a place where comfortable benches are few, far between, and diminishing every year. Every session, therapists are forced to confront and understand the physical world their patients inhabit, as well as the dynamics of status and class. Like in TA, street therapists "immerse [themselves] in the patient's individual universe." Patients, meanwhile, are given the choice not to assimilate. Tietboehl says that in therapeutic work like this, patients with psychosis are not required to constantly try to adapt to their environment.

The work is certainly susceptible to intrusion or interruption, as in TA. But the "intrusions" of the environment become part of the dialogue, and Casagran Lopez says that can take the edge off the pressure to process or quickly disclose intimate information. It also allows for more dynamic free association. These aspects of street therapy—the landscape's holding capacity, and the way that therapeutic space is constructed via the patient's associations—echo Chrzescijanska's turn toward "psychogeotherapy," introduced above.



The reality is that not all patients deserving of psychotherapy live in areas with access to good walking paths or magnificent, awe-inspiring nature. Our cities are often banal, inconvenient, and marked by structural violence. For people who live in unsafe settings, walking may at times pose more risk to the therapeutic relationship. For both patient and therapist, however, walking through a local landscape "imbued with social suffering and traumatic memory," as Lena Sawyer and Kris Clarke write, may open up new ways of experiencing that place. This risk seems worthwhile given its dual potential to leave room—space, even—for the therapy: for healing, growth, and transformation. ■

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“Vain trifles as they seem, clothes have, they say, more important offices than to merely keep us warm. They change our view of the world and the world’s view of us.”

—Virginia Woolf, *Orlando* (1928)

CLOCKWISE FROM TOP LEFT:

Fetish Boots c.1895 ©Francesca Galloway, photo Katrina Lawson Johnston.

Larry Shox man's suit, 1985 USA, photo Eileen Costa.

Elsa Schiaparelli evening jacket, 1939 ©Francesca Galloway, photo Katrina Lawson Johnston.

Jean Paul Gaultier suit, 1996, photo Eileen Costa.

All images courtesy the Museum at FIT. The exhibition *Dress, Dreams, and Desire: Fashion and Psychoanalysis* is open through January 4, 2026.

MIND AND BODY

WHATEVER HAPPENED TO PSYCHOSOMATICS?

BY NEAL SPIRA

IN THE BEGINNING there were our mothers, so to speak: the five women whose stories make up the case reports in *Studies on Hysteria*. Anna, Emmy, Lucy, Katharina, and Elizabeth communicated their mental suffering through disabling somatic symptoms like pain, visual impairment, severe breathing difficulties, spasms, and paralysis. For Drs. Breuer and Freud, these ailments of the body became the doorway to the mind. How strange it is, then, that the body has all but disappeared in our psychoanalytic rearview mirror!

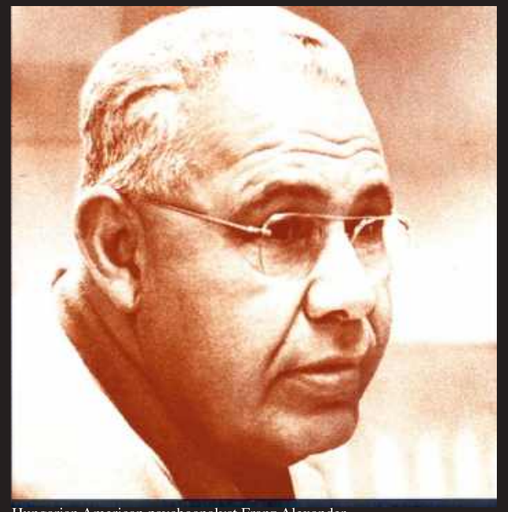
If it's true that "the body keeps the score," as Bessel van der Kolk wrote in his bestseller of that name, why has American psychoanalysis shown so little interest in psychosomatic phenomena? After all, in this fragmented world the body is one thing we human beings all have in common. This essay is my attempt to offer some thoughts about how we've left the body behind and generate some interest in reclaiming it. In what follows I will explore a number of developments within psychoanalysis and in American society that I believe have kept us psychoanalysts from taking a place at a table where we surely belong.

HEALTH CARE—THE PROVINCE OF THE BODY—IS AN INDUSTRY THAT SEEMS TO BE LOCATED ON A DIFFERENT PLANET THAN THE ONE WE PSYCHOANALYSTS OCCUPY.

Illustration by Austin Hughes

From Chicago to Paris

Freud was a neurologist interested in treating patients who suffered from distressing symptoms of nervous system dysfunction that defied medical understanding back in the late 19th century. One of his earliest insights was that some of these symptoms could be understood as symbols that represented past experiences which could not be allowed into consciousness. This led to a unique way of addressing somatic dysfunction: by providing insight through interpretation. It worked! Psychoanalysis became the first mind-body treatment in Western medicine.



Hungarian American psychoanalyst Franz Alexander was a founder of psychosomatic medicine.

Freud didn't have much interest in the link between the psyche and the larger corpus of "medical illnesses." But there were other psychoanalysts like George Groddeck, Sandor Ferenczi, and Felix Deutsch who found this territory compelling. The first systematic psychoanalytic mind-body studies were conducted in the USA where Franz Alexander and Helen Flanders Dunbar founded the Chicago School of Psychosomatic Medicine.

Alexander proposed that every disease was psychosomatic because both psychological and somatic factors take part in its causes and influences its course. He pointed out the intimate connection between acute emotions and their influence on the autonomic nervous system.

While Alexander used the term "psychosomatics" broadly, he believed that there were certain specific physical disorders in which symptoms were the expression of unconscious conflict mediated by a chain of physiologic events that led to pathology. Symbolism was still involved, but indirectly, and in the sense that the affected organ system had a historical connection to earlier developmental mind-body struggles.

A prime example for Alexander and his group were gastrointestinal disorders. The link between mind and the gut had been well established by medical science for hundreds of years and is well known by anyone who has had "butterflies in their stomach" or experienced the effects of increased gut motility that accompanies anxiety. Alexander theorized that the gastrointestinal system was especially suited to express that which could not be expressed in words. Alexander was clear in pointing out that the connections here between unconscious psyche and soma were not directly mediated by symbols. This meant that interpretation of unconscious material was not likely to provide meaningful relief without getting a better handle on the mediating physical factors that were waiting to be discovered.

In 1932, Alexander and his colleagues began a series of studies of patients suffering from chronic organic ailments. They focused on seven specific conditions: bronchial asthma, rheumatoid arthritis, ulcerative colitis, essential hypertension, neurodermatitis, thyrotoxicosis, and duodenal peptic ulcer. The study went on for over 14 years and yielded what the group regarded as confirmation of their hypothesis that these conditions reflected particular psychological constellations.

The Chicago group acknowledged that these patterns were not specific to those individuals suffering from the specific diseases studied and that other factors including the constitutional must be at play. They also were aware of their own potential for bias. In that spirit they recommended follow-up research including clinical material derived from the psychoanalytic treatment of those with one of the diseases they had studied.

As far as I can determine that project never occurred, and the research path of the Chicago group was dropped like a hot potato. Alexander's work was widely criticized on methodological grounds, and these criticisms surely must have had an impact on anyone considering picking up where he left off. But in retrospect it seems somewhat unusual that there were no further attempts to develop, expand, or present alternatives to Alexander's ideas. In any event, this is where the road of psychoanalytic research into psychosomatics ended, back in the mid-20th century.

In the United States.

Actually, it hopped across the Atlantic.

As an illustration of where we could have gone, consider the road that French psychoanalysts set upon in the 1960s and that they have continued to follow until today. The Paris School of Psychosomatics was founded in 1962 by psychoanalysts Pierre Marty, Michel de M'Uzan, Michel Fain, Christian David. The basic idea behind their work was that the body itself was a psychosomatic entity, and that the Freudian concept of the drives was of pivotal importance in understanding the back-and-forth interplay between soma and psyche. For these analysts, optimal health required that "libido" (understood as a "life force") operate in harmony with the "death instinct." Under conditions of emotional overload, the two drives become imbalanced, leading to various degrees of physical expression—in some cases, actual death.

As opposed to Alexander, who looked for meaning in specific physical symptoms, the French viewed physical symptoms as the result of a more general reaction to emotional overload. They introduced a particular terminology to express the way in which strong emotions could find mental expression through imagery and fantasy in some but not others (mentalization). They also identified that there were many individuals in whom the capacity for mentalization was lacking, supplanted by "operational thinking" and an inclination toward somatic expression that in some cases became pathological ("essential depression").

In France today, it remains common for psychoanalytic clinicians to work in concert with medical practitioners to approach somatic illnesses from both directions. That is, analysts try to track the emotional climate changes that accompany the patient's physical course as followed by their physicians.

Psychosomatics Outside Mainstream Psychoanalysis

How different the situation is in the United States where the divide between mind and body seems to be getting wider and wider. Health care—the province of the body—is an industry that seems to be located on a different planet than the one we psychoanalysts occupy. This is especially notable since we are living at a time when the connections between mind and body have been worked out to a degree that was only speculative in Alexander's day. The pathway from emotion (i.e., affect) to inflammatory processes has become more explicit as we have come to understand the role of these processes in so many contemporary ailments.

A brief version of this exciting and unfolding story needs to begin with the work of Candace Pert. Pert was a psychopharmacologist who achieved fame when she identified the "opiate receptor" that could be turned on by small molecules—peptides—that float through our systems and are intimately connected with our emotional states. These "molecules of emotion," as Pert called them, can act all over the body, at great distances from where they originate. According to Pert's stress and disease model, emotions can either enhance or suppress the immune system through the synthesis and release of neuropeptides throughout the body.

The manner in which peptides mediate the space between emotions and organ systems is currently being elucidated from numerous corners. Acute and chronic stress, peptides, immune responses, and inflammation have been implicated as links in a pathophysiologic chain common to a host of contemporary diseases.

This emerging awareness of the way in which emotions are related to physical health and illness has led to an increased public appreciation of the importance of psychological well-being to overall health. But the psychological approaches that have followed from this contemporary recognition have come from outside of psychoanalysis. In our contemporary medical framework they reside within a model that for the most part looks at psychological turmoil from the outside in—as something that one "has," to be controlled and eliminated through the application of some remedy administered by a "treatment provider." This misses the most important ingredient of the psychoanalytic approach to the mind, which is its emphasis on subjective experience and the unconscious.

Today, in America, the language of subjective experience and its reciprocal relation with the body is spoken for the most part by therapeutic schools outside the psychoanalytic mainstream. For example, the field of transpersonal psychology, which has its roots in the work of Carl Jung, humanistic psychologists like Abraham Maslow, and psychedelic psychoanalysts like Stanislav Grof, has had a close relationship with bodily experience as well as an openness to the language of spiritual experience. Additionally, there has been a surge of interest in trauma-based therapies that focus on bodily regulation as a prerequisite to entry into the world of the psyche, especially those informed by the polyvagal theory of Stephen Porges. Up to now, there have been few bridges built between these domains and the mainstream psychoanalytic community, but building these bridges may be a necessary part of taking the body seriously again in psychoanalysis.

Psychosomatics Today: What Happened?

In trying to understand the absence of psychosomatics from the American psychoanalytic scene, I would now like to offer some speculations about a number of factors that may have contributed to its disappearance since the days when Alexander was trying to fill in the dots that connected psyche and soma.

As mentioned above, one of the aims of Alexander's research was to demonstrate that a connection could be made between specific body pathology and psychopathology. But the nature of this connection may have been too indirect at a that time when, in the public eye, psychoanalytic cure meant "insight through interpretation." Interpretation had a magical quality to it of the kind that we tend to associate with "miracle drugs" and raised expectations accordingly. It seems likely, from the vantage point of contemporary psychoanalytic experience, that insight and interpretation fell short of fulfilling such expectations when it came to treating physical illness and that, as a result, enthusiasm for the psychological approach in this area might well have gone by the wayside—both for patients and psychoanalytic practitioners.

But the fantasy of cure by interpretation is connected to a historic dilemma in psychoanalysis regarding the role of traumatic events in symptom creation. Very early on, Freud decided

that his patients' reports of childhood sexual abuse were best understood as repressed, wish-driven fantasies. The analytic cure became a matter of interpreting such fantasies, which promised relief for the patient and a degree of narcissistic satisfaction for the interpreter. This general mindset may have interfered with an appreciation of the real impact of the social surround on the psyche, such that psychoanalysts tended to underemphasize the way that traumatic stories can be encoded in physical reactions (as Van der Kolk argues) because they were not encoded as interpretable symbols. Again, the argument would be that just as surgeons like to cut, psychoanalysts like to interpret. That is, analysts tended to downplay possible treatments (and etiologies) that function in a nonsymbolic way. So a combination of public disappointment and professional lack of interest may have converged and impacted on the pursuit of the connection between psychic distress and somatic disease that Alexander and his group was trying to piece together.

Another factor may relate more directly to Alexander himself and his relationship with the psychoanalytic establishment of the time. By the 1960s, Alexander's thoughts about shortening treatment and his concept of "the corrective emotional experience" had placed him at odds with mainstream psychoanalysis and with his own institute. He moved to California, where he continued his work (including work in somatics). But with his reputation thus tarnished, it seems likely that there was considerable general group pressure to separate from all things Alexander.

From a broader perspective, one cannot overstate the importance of changes in the field of psychiatry and in medicine that were taking place in the United States. During the Alexander years, psychoanalysis and psychiatry were practically inseparable. Most department heads in University psychiatry departments were analysts. This was about to change, dramatically and rapidly.

Unlike in other parts of the world, and counter to Freud's own attitudes, America had resolved the question of "lay analysis" by trying to restrict practitioners to the medical field. At the same time, the medical field was becoming disillusioned with psychoanalysis as a new generation of medications became available that impacted favorably on many conditions that had been considered the province of psychoanalysis, which did not provide the symptomatic relief that patients and the medical insurance industry desired. The "psychology" of psychiatric conditions became secondary to an appreciation of the constitutional factors (often referred to as chemical imbalances) underlying psychiatric illness. It's not surprising that there was little room for those interested in studying physical illnesses from a psychoanalytic perspective!

TODAY, IN AMERICA, THE LANGUAGE OF SUBJECTIVE EXPERIENCE AND ITS RECIPROCAL RELATION WITH THE BODY IS SPOKEN FOR THE MOST PART BY THERAPEUTIC SCHOOLS OUTSIDE THE PSYCHOANALYTIC MAINSTREAM.

As psychiatrists increasingly moved away from psychoanalysis, the psychoanalytic field was regenerated (one might well argue "saved") by the entry of nonmedical professionals, assisted by a lawsuit that broke the medical monopoly of the American psychoanalytic establishment. But as psychologists and social workers entered the field, proximity to the body may have waned further in favor of hermeneutic and relational approaches which focused on a psyche that was unlinked to the soma.

Farewell to the Drives?

A central issue here seems to have been the departure from Freudian "drive theory" in the United States and its continued presence abroad. By the end of the 20th century, there was a strong reaction to Freud's biological orientation as well as a greater appreciation that the universe can't be objectively understood, independent of our subjective position as participant observers. This means that what happens in psychoanalysis involves the psychological processes of two people, not one. The intricacies of this two-person experience in the here and now took center stage.

But in this atmosphere, the link between psychoanalysis and the body was weakened, if not broken altogether. Debates about the true nature of psychoanalysis began revolving around the question of whether psychoanalysis is a natural science rooted in the material world (Freud's position from the start) or an interpretive discipline akin to literature and circumscribed by the limits of subjective experience. Prominent analysts like Gill, Hoffman, Laplanche, and Schafer among many others took deep dives into the latter waters.

Perhaps this kind of retreat from the biological offered a potential safe harbor for those trying to protect psychoanalysis from attack by those who challenged its scientific merit (by placing in a category that defied the traditional measurement techniques of natural science). But one of the casualties in this evolution may well have been a full appreciation of the unique importance of the drive concept to psychoanalytic theory.

Freud's term *Trieb* (translated as "drive" or "instinct") is ambiguous: Is it a mental phenomenon or a bodily one? In "Instincts and Their Vicissitudes" ("Triebe und Triebschicksale"), he described it as

> a concept on the frontier between the mental and the somatic, as the psychical representative of the stimuli originating from within the organism and reaching the mind, as a measure of the demand made upon the mind for work in consequence of its connection with the body.

The very ambiguity of the term solved the kind of problem we are struggling with today, presuming a mind-body connection as a foundational principle of psychoanalysis. Freud did not let what is called "the hard problem" of consciousness in philosophy ("how does the physical brain give rise to subjective psychological experience?") interfere with his observations or theorizing about the disturbances in the connection between our minds and the matter of our physical existence.

The concept of drive itself is really a metaphor that provides entry into territory that invites further exploration as an essential part of the psychoanalytic mission. It is no accident that the French psychosomatic school has retained the language of drive theory as they have continued their work on the psychosomatic frontier, while in the United States we have, for the most part, abandoned the language and the pursuit.

One very notable exception is the emergence and growing American interest in "neuropsychoanalysis," which has acknowledged the importance of the psychosomatic link with regard to current understanding of the brain. Mark Solms clearly articulates the relevance of drive theory to psychoanalysis:

> If the mind is part of nature, then it is *embodied* (what else can it be?); and it is from this simple premise that Freudian drive theory starts. … To abandon drive theory is to abandon this insight, which is the essential connection between psychoanalysis and the body, and, indeed, with the life sciences as a whole.

What Solms expresses so cogently, from the perspective of neuropsychoanalysis, clearly extends beyond the brain to the body as a whole.

Medicalization

In addition to what might be called a "return to dualism" resulting from political and theoretical changes in psychoanalysis and psychiatry, there has been cultural move toward what one of Alexander's colleagues, Thomas Szasz, had termed (along with others) "medicalization": a tendency to reify unpleasant bodily experiences and label them as "diseases" that required "treatment."

This sociocultural vector surely motivated the departure of medically trained and physically oriented psychiatrists from the psychoanalytic field as mentioned above, as it created financial incentives that promoted participation in a system of care that has been intrinsically in conflict with the psychoanalytic worldview.

The effort to meet with the standardization that governs American medical practice led to the DSMs and to an evidence-based approach to medicine that, despites its many benefits, also inflicted some degree of collateral damage as new diseases were added by committee, often in concert with the emergence of drugs tailored to meet these new illnesses.

Perhaps the most relevant example of how this relates to the mind-body interface is the now well-known story of how Purdue Pharmaceuticals medicalized the experience of pain to create a market for a new version of an opiate, OxyContin. In short order, "pain assessments" became part of standard medical practice, paving the way for excessive use of these medicines and contributing to the addiction epidemic we see today.

One of Freud's most useful concepts was what he called "the secondary gain" of illness. Secondary gain refers to the benefits inherent in the sick role—like being taken care of. As Freud noted, the gratification sometimes obtained from being ill is hard for the individual to give up. By way of analogy, we might then think of a sociocultural secondary gain that benefits the prevailing social and economic order by defining the emotional collateral damage of that order as medically treatable illnesses.

In a sense, this is where Freud began. The emotional collateral damage that expressed itself as "hysteria" had a lot to do with his patients' reactions to the Victorian status quo of his time. Medicalization is a particularly useful mode of defense for the societal status quo, serving to bury conflicts that arise between individual psychological needs and the social order. There is a clear advantage to those invested in the status quo to medicalize and tip the scale in the direction of the somatic, without regard for the psyche.

But in this "full-circle" moment there is also a great opportunity for us to remember where we came from and to reassert our interest in the frontier between the two. ■

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HANDLING POSITIVE TRANSFERENCE

BY STEPHANIE NEWMAN

Dear Psychoanalyst: Can a positive transference be more problematic than a negative one?

—Dr. S., Clinical Psychologist

Hello Dr. S.,

Good question—this is one of our field's greatest hits, right up there with couches and dreams about teeth falling out.

I see you're a clinician, but you're also likely a patient. Working with the transference can be a challenge on both sides of the couch. Intensely positive emotions towards a therapist can feel burdensome for patients and prove to be a handful for even the most seasoned clinicians. The sudden incursion of, say, adoration or erotic desire may make discussion difficult. You might find it hard to bring up intensely admiring feelings or erotic fantasies about your therapist or analyst. Or you might be skeptical about whether idealizing or erotic transference is an issue that needs attention at all.

Let's start with a definition. Emotions and fantasies about significant people or experiences from the past are often transferred onto present day people and experiences. This is what we in the therapist's chair like to call transference. Think of it as emotional time travel: The patient's thoughts and feelings hitch a ride from the past and arrive with you in session. These can be negative ("you don't give advice, why don't you care about me?") or positive ("I finally feel seen!"). Warm and fuzzy, loving, erotic, and admiring feelings routinely develop during the course of a treatment and land squarely on the person of the therapist. All this because the patient has cast you in a familiar role (or more than one role!) that may have little to do with you in reality.

So, what could be so bad?

Psychoanalysts have been discussing the pitfalls of positive transference for years—about one hundred, to be exact. An old guy with a white beard (you know the one) noticed a young female patient's intense response to their sessions, which felt like a distraction from treatment. Then it happened with other patients. Eventually, understanding he was not *that* attractive, he realized it wasn't about him; it was a relic from the past, one that could be interpreted. While he cautioned against *prematurely* interpreting the transference, he did come to see transference as the stuff of therapy, not an impediment to it. When our man's model of the mind shifted to conflict between Id, Ego, and Superego, clinicians began to recognize a kaleidoscope of

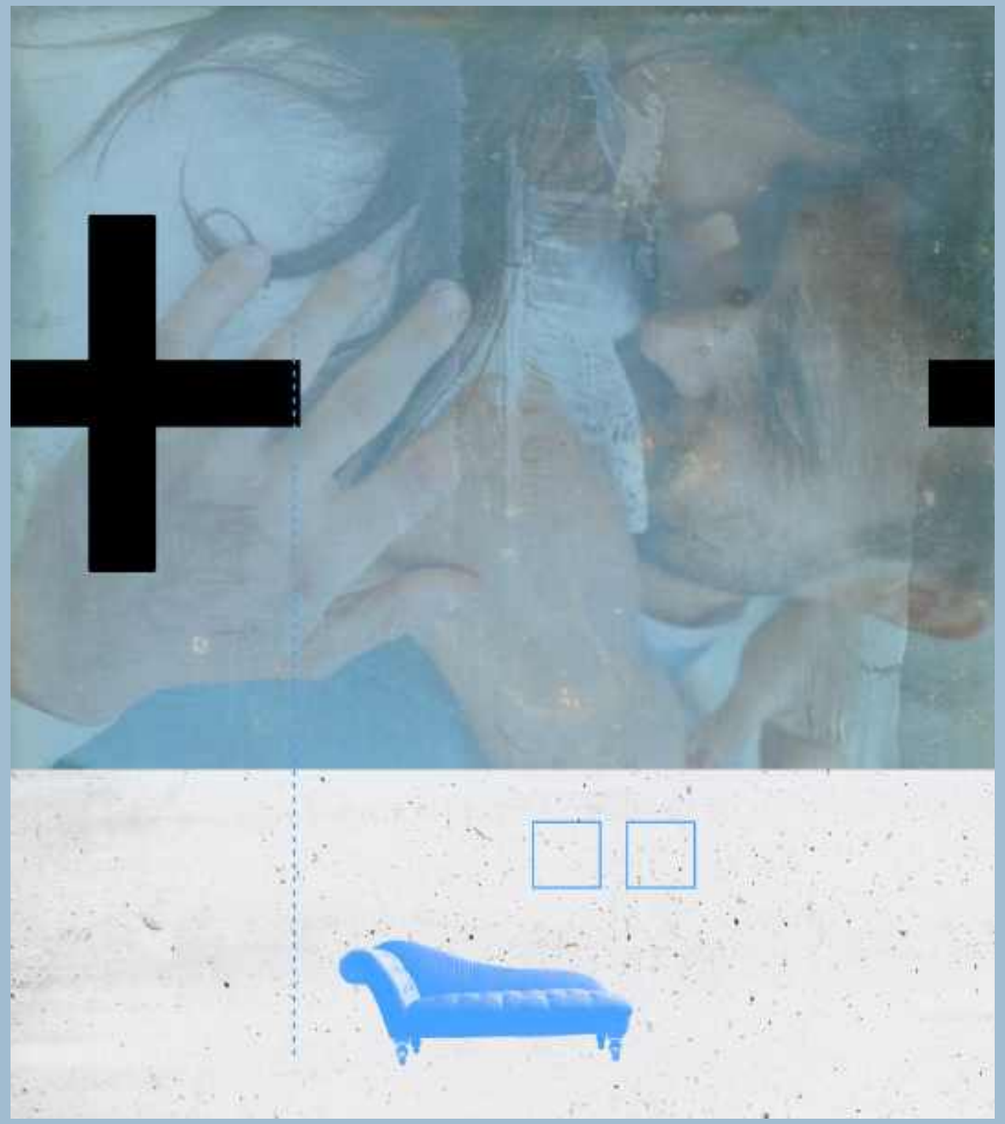

Illustration by Austin Hughes

“NAMING THE ELEPHANT IN THE ROOM—AN ELEPHANT CALLED EROTIC TRANSFERENCE—TURNED OUT TO BE HEALING.”

thoughts, feelings, and defenses against them, alongside fantasies about the therapist-patient relationship. These transference fantasies, positive and negative, were a tool to aid in analyzing.

Fast forward a few decades and theoretical approaches to transference emphasized what was happening between therapist and client, the “here and now transference” (Merton Gill, we mean you!), a relationship built in real time that does not merely recapitulate the past. Some took this idea a step farther, positing that struggles in the consulting room would be best addressed by untying present-day knots between patient and therapist—no need to go back in time and revisit “old feelings” to shed light on current struggles. Maybe the feelings come from the past, according to this view, but the way to deal with them is in the present relationship. Here it’s less about watching reruns of the patient’s life and more about shooting a new season.

Theories of transference are a-plenty, and most modern psychodynamic approaches agree that a combination of developing insight and experiencing a new relationship is what makes people better.

It’s clear that negative transference is a problem worth reflecting on. There’s reticence and defensiveness at play. Embarrassed or ashamed people can become tongue-tied, judge themselves, and put their self-criticism onto others, especially their therapists. But you might remain unconvinced that positive feelings are a problem. If so, consider two scenarios: (1) idealizing, intensely loving feelings and thoughts and (2) powerful erotic experiences and fantasies. If idealizing and erotic transferences lurk, treatment can stall.

Silence is not always golden. Here’s how. Some go to all lengths to avoid whatever is taboo in their eyes: sexual, angry, vulnerable feelings are commonly uncomfortable. So, someone who grew up in a home full of conflict, angry blowups, extended absences of a parent, or use of the silent treatment may have learned that anger is toxic and may avoid conflict by being nice and pleasing others, including the therapist. Some might aspire to be the “perfect patient,” striving to be likeable, complimenting the analyst, putting them on a pedestal. Piling compliments on your analyst might feel polite, but it can be a red flag: Somewhere under all that sugar there’s probably a little vinegar. Looking at idealization, allowing a full range of feelings (even negative and critical ones) into the treatment room helps integrate them into the patient’s awareness, allows for authenticity, and helps us feel more comfortable in our own skin.

Like idealizations, feelings of desire can be difficult to know and discuss—even with a therapist. I once supervised a female clinician whose male client made progress by talking about career concerns. He was positive about treatment and asked to see the therapist four times a week. He decided spontaneously to lay down on the analyst’s couch. Next session he came in ready to argue, railing against a female boss who had “misled” him about a promotion and speaking about a romantic partner who had “led him on” and “hurt” him. He yelled that treatment was not helping. He shouted, “This is what it’s like to be married to me!” and stormed off. The patient did not return my supervisee’s follow-up calls but wrote a note apologizing for the outburst and ending the treatment. After some time he was able to return and connect intense feelings of attraction for the trainee therapist to his need to storm out of the treatment and leave on angry terms. The patient later began to explain the source of his pain: In his community sexual attraction outside marriage was taboo. In his family love was stormy and full of ups and downs. Naming the elephant in the room—an elephant called erotic transference—turned out to be healing.

In my view, progress is deterred by what is left unsaid or unlabeled because it is too threatening or shameful or taboo. Talking it through, feeling it, tolerating what is scary or dangerous, allows a person to integrate frightening thoughts and emotions. If a feeling or topic feels unspeakable, all the more reason to label and address it. I agree with the many psychodynamic clinicians who believe that whatever doesn’t get discussed gets acted on, often emerging when we least expect it. What isn’t understood and labelled comes back to bite us.

As clinicians we open up a path to progress by showing we are comfortable with whatever patients put onto us. If we can take it they see it must not be so bad, and they can integrate it and feel less overwhelmed and anxious.

If you are seeking advice about your own treatment and how to approach “positive” fantasies and feelings, I’ll reiterate: I hope you’ll communicate your emotions and concerns to your analyst. Understanding transference opens doors. It might not be easy, but it will likely open up new areas of exploration in your treatment. ■

In Ask a Psychoanalyst, ***Stephanie Newman, PhD****, responds to reader questions about therapy, relationships, and psychopathology of everyday life. Submit your questions to advice@tapmag.org. Your identity will be kept anonymous.*

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"We are trying to satisfy two contradictory tendencies by means of our clothes, and we therefore tend to regard clothes from two incompatible points of view—on the one hand, as a means of displaying our attractions, on the other hand, as a means of hiding our shame."

—John Flügel, *The Psychology of Clothes* (1930)

Image courtesy Clark University.

The New York Times has called it a "Freudaissance."

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