The Role of Theory
Talking to patients exposes us to enormous pressures to understand what we are hearing, to be helpful, and to avoid being harmful. When we feel inundated by material we do not understand, we frequently become anxious, and our anxiety, if sensed by our patients, could be frightening to them. Staying calm, even when confused, is half the battle; staying emotionally connected with our patients is the other half.

Theory provides a structure that helps us organize our thinking, remain calm, and stay connected. Lindon (1991) says we need theories "to help us organize what otherwise is a chaotic jumble of meaningless material and to widen our perceptual scope" (p. 15). Staying connected with patients is hard when we doubt ourselves, but having a theory to anchor us, even one that challenges our own, helps us maintain that connection. It gives us the confidence to assure our patients that we will get through these difficulties together, even if we do not understand everything that is happening.

Although we have learned much about the psychoanalytic process, much that takes place in psychoanalysis is yet to be understood. We cannot take our theories for granted, but must be willing to question them, aware that while theory can help us, it can also hinder us. Theory, followed too closely, can lead to mechanical behavior and can stifle creativity. It can lull us into a false sense of security when we think we understand, and then encourage us to jump to conclusions and prematurely discontinue necessary psychoanalytic investigation. Knowing the next question may be more important than knowing the answer.
Theory, the way we understand clinical material, influences how we talk to patients, and is conveyed to patients by our attitudes and interpretations. Yet theory does not always translate into technique, and research shows that analysts from the same theoretical school may work very differently, while analysts from differing theoretical schools may work similarly (Hamilton 1991).

I was surprised to find much in common with experienced analysts from different theoretical schools in the way we talk to our patients. In dialogues where we presented cases to each other, many of our interpretations were similar. I believe that sensitive therapists use their intuition while looking for what works and what does not work. Over time, as they gain experience, these therapists rely less on theory and more on learning from their patients. Self psychology has changed the way I listen to patients and understand our interactions in (1) the shifting to a two-person psychology model and (2) the understanding and interpretation of motivation and resistance.

TWO-PERSON PSYCHOLOGY

When I worked in a classical, one-person psychology model, I understood transference feelings—the ways in which patients experienced me—as arising from forces solely within the patients. I believed that I was neutral, even-handed, and unknown, and that my patients' experiences of me were distortions based on projections, which I interpreted.

Working in a two-person model, I view patients' feelings as determined by their past experiences and by current perceptions of me. Patients pick up cues from behaviors and attitudes that I do not always intend or realize.

An example of this is Mary, a 28-year-old depressed woman with a history of molestation by her brother and stepfather. She left a therapist four years earlier when he tried to seduce her, and
she expected me to "blame" her for her "masochistic" behavior and to hold her responsible for being molested. When I did not, she felt safe, and as she felt understood, her depression lifted.

Then, after six months, her mood changed from eagerness to see me to dread of the sessions. Her comfort in being with me changed to restless agitation. "I hate coming here!" she would announce. "I can't stand these sessions. There is no point in continuing. I'm getting worse instead of better."

Anything I said was of no benefit and even upset her further. I felt helpless and guilty, and so, as is my wont, I tried harder. She felt patronized and said I was just using her, pressuring her to talk about painful experiences and causing her to feel humiliated. I felt misunderstood and unappreciated and became irritated with her. I, too, began to dread the sessions. She complained either that I wanted her to change into what I expected or that I was aloof and indifferent and didn't care if she changed at all.

I felt stuck and in a no-win position, and thought of interpretations I might have made in the past. I could point out that she was feeling frightened at the increasing closeness in our relationship, and resisting being involved with me, but this could make her feel inadequate and defeated. I could point out that she was struggling with feelings of anger toward me that were a displacement from the past, but I knew that would make her feel hurt and criticized. I could point out the distortions in her perceptions of me, but that would make her feel discounted, as she did with her mother. This way of thinking, while accurate at some level, was not central to her experience, and is a one-person psychology model, which puts the essence of the difficulty only within her.

Winnicott (1960a), defining a two-person model, said there is no such thing as an infant, explaining that there can only be an infant and maternal care. Applying this to psychoanalysis, there is no such thing as a patient; there can only be a patient—analyst dyad. The patient's
experience of me may be determined by early experiences, but these reactions are precipitated by some current perception of me.

Since this perception is codetermined by her past experiences and her perception of my behavior, I wanted to find out what I did that set Mary off before looking at the contributions from her past. I systematically explored my contributions to her transference reactions of agitation and fear. Each time she felt upset with me, I observed that there was more tension and distance between us, and I asked her to help me understand what had happened. Could she remember what I had said that was patronizing, critical, pressuring, or discounting? I would then listen very carefully, trying to see her perspective until I could say, "Yes, now that I hear my words coming back to me, they do sound patronizing. It's no wonder you feel hurt and angry. Thanks for bringing this to my attention."

I did not apologize for what I said, but tried to appreciate the impact my words had on her. Her reactions to me were precipitated in some way by her perceptions of me, and although from my point of view her perceptions may have been distorted, I wanted to see her reality. I did not have to agree or disagree with her; I just had to understand her.

When she felt taken seriously, she became calm and settled, and then became sad, telling me she had overreacted. My seeing things from her perspective helped bridge a gap between us, enabling her to see things from my perspective without having to be compliant. After much repetition of this interaction, she realized that her reactions to me were familiar, and she spontaneously recalled new memories of being hurt, humiliated, patronized, and demeaned by her parents and her brothers whenever she did not comply with their expectations.
MOTIVATION AND RESISTANCE

When I worked in a classical mode, I understood resistance as patients running away from themselves and from me. Motivated by conflicts over innate aggressive and incestuous strivings, patients did not want to be made aware of their unconscious wishes to confound or defeat me. From this viewpoint, my interpretations were confrontational and authoritative. For example, John, a man in his mid-thirties, would, from time to time, point out my shortcomings. I understood and interpreted these criticisms of me as expressions of underlying anger stemming from an unconscious aggressive drive. I believed he was unconsciously hostile and competitive toward me, an expression of his Oedipus complex, a normal phase of development. John acquiesced to these interpretations and felt guilty, like a naughty child, and his already poor self-esteem deteriorated. I saw his acquiescence as confirmation of my theory.

From the perspective of self psychology I came to see patients not as striving to defeat me but as striving to grow, develop, and protect themselves. I changed my approach.

Two years later, John began a session with the statement, "I see that you wear a gold chain. I think that's really tacky!" He then began putting himself down for being so "angry." I thought he might be putting himself down in anticipation of my interpretation of his anger, his way of protecting himself from my critical interpretations, so I asked him if that seemed like anger. He said, "It sure sounds like anger to me. Doesn't it sound like anger to you?" I said that it did not feel like anger to me, but sounded as if he was trying, somewhat awkwardly, to express his own opinion, to pursue some of his own ideas. I saw his assertiveness as a reaction to feelings of enmeshment with me and his attempt to extradite himself.

Reframing his behavior had a powerful impact on the analysis. He was no longer a naughty boy being obnoxious, but was, instead, a frightened man struggling to find his voice. When I had
seen him as angry at me, he felt criticized and frightened of losing me. He believed that if we became disconnected, he would lose all the gains of his analysis. He had to comply, to "kow-tow" in order to maintain my support, and this made him feel enslaved and humiliated. He was torn between being his own person and keeping me happy, and did not believe he could do both, or that he had a right to develop as an independent person. As this new understanding became conscious, his individuation resumed its course with an improvement in self-cohesion and self-esteem.

While working in a traditional model, I viewed his anger as a manifestation of aggressive drive energy directed at me, but from the perspective of self psychology, I saw his anger as assertiveness in the service of self-individuation development (Mahler et al. 1975). These changes in understanding have modified my attitude toward patients and my interpretations of their responses.

**Insight**

Traditionally the goal of psychoanalysis has been insight, to make the unconscious conscious, but contributions from relational theory show that insight may not be necessary. For example, a patient who believed that asserting himself or complaining to his mother hurt her, may now look to see how the therapist reacts to complaints.

If the therapist, because of his own way of being in a relationship becomes anxious or feels guilty, the patient gets more anxious. If, however, he is sympathetic and understanding, and even appreciates the criticisms, a new relational experience can develop that proves to be therapeutic for that patient at that moment. It could help him disconfirm his automatic belief that complaining or self assertion is destructive to a relationship. These new ways of being in a relationship may or may not be subject to interpretation and insight, but in this way of thinking, it doesn't matter.