PSYCHOANALYTIC COLLISIONS

Second Edition

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THE IDEAL AND THE ACTUAL

I was virtually born into this field: my parents were both Freudian analysts. My mother’s office was in the apartment, an off-limits enclave protected by frustratingly soundproof doors. Growing up surrounded by my parents’ very grown-up psychoanalytic friends and colleagues, I never thought I’d get old enough to be on the mentorship side of the professional equation: they knew, I was just a kid.

Though I have been blessed with inspiring teachers and supervisors, my first psychoanalytic mentor was my mother. She was a rule-bound mother and I was certain that she was a rule-bound analyst. So imagine my surprise when I, a young adolescent, heard her mention that she was helping her patient get an abortion. (Hard to believe that it was illegal in those days. But it was very.) “But you’re not allowed to do that, are you?” I asked.

My mother’s answer was simple and simply stunning: “Either we’re in the business of helping people or we’re not.” Although she was committed to a classical model, if—in her view—psychoanalytic rules failed the patient, she matter of factly threw away the book. I couldn’t process what this meant then, but I never forgot what she said.

Certainly, we can question my mother’s certainty and wonder whether the help she offered was, in the end, the best way to help. Might she have overlooked her patient’s conflicted feelings about giving up that baby? Might my mother’s own worries about out-of-wedlock pregnancies have influenced her to intervene? And who knows what else.

It’s naive to assume that we can ever be sure how best to help a patient; we’re constrained by our subjectivity—our anxieties, biases, and needs—and by the limits of what we can know about ourselves and our patients, no matter what would best help them.

Yet despite all this, I remain inspired by the ideal my mother articulated. It’s foundational to an ethical psychoanalytic identity because it privileges the “care” element of analytic practice, a willingness to address patient need over our theory and the clinical stance it seems to demand. Even if we meet it most imperfectly, it’s an ideal worth aiming for.
To be—first and last—in the business of helping people, to privilege patient need in all its complexity is my red thread; it’s an implicit professional ideal that my mother taught me and it’s one that has remained with me all these years. And if I do no more than pass that particular ideal on to those I train, I’ll be more than pleased. It’s with this ideal in mind—an ideal that supersedes the particulars of the professional identity we embrace—that I turn to the development and evolution of our theoretical ideal. I begin by describing my own professional trajectory.

How and why we choose: psychoanalytic models and psychoanalytic ideals

When I first decided to enter the field of psychoanalysis, I half unconsciously envisioned the analyst I would try to become as a female Freud: wise, penetrating, able to help patients face the unthinkable, emerge stronger and more resilient. Freud’s (1912) metaphor of the analyst as a surgeon was as repugnant to me as my high-school dissection labs, but I was inspired by Bibring’s (1964) description of the model analyst, qualities he associated with the fundamental virtues of ancient Greece:

Wisdom, as represented by the understanding of human nature and of the intrapsychic processes in oneself as well as in others; temperance, by the ability to deal with and to tolerate the patient’s transference, his emotional appeals or attacks; justice, by the neutrality and ability to suspend judgment until things speak for themselves; courage is needed to pursue the truth, to confront the patient with issues he vehemently denies, and to avoid comfortable compromises.

(p. 518)

I tried, but only briefly. I was too young to be wise, too emotionally reactive to sustain a position of temperance, too uncertain about my understanding to quite know what justice was and far too frightened of my Freudian supervisor to be courageous.

I went into analysis with someone influenced by both interpersonal and object relations orientations. Aware of a clash between my Freudian training and my analyst’s way of working, my Freudian ideal ruptured, leaving me temporarily destabilized. I moved away from the Freudian model, enthralled by object relations theory and my experience as a patient. If I couldn’t be wise and penetrating, I could be steady and reparative; I could do for my patients what I wanted my analyst to do for me.

The image of a reparative parental analyst—gentle and playful—was captivating. I imagined myself both behind, and on, Winnicott’s couch. I longed to emulate his wise maternal/paternal stance, his capacity to mother and meet his patient’s need, while maintaining a quality of depth and deep connection to unconscious process.

Wanting to absorb all Winnicott knew and recreate the therapeutic ambiance that his writing inspired, I mightily embraced this object relational ideal. I would nurture my patients, repair what plagued them, provide them with symbolic milk and (British) biscuits.

But I couldn’t do it. I was both less playful and less maternal than Winnicott seemed to be. I wasn’t always sure what my patients needed or how I could be helpful. I felt too young to assume a parental position and, more often than not, confused about the layers of meaning that Winnicott seemed so facilely to absorb and understand.

Equally troubling was the gap between the patients’ imagination conjured and those I confronted. Clinic patients weren’t even vaguely Winnicottian; they were erratic rather than faithful, irritable more often than dependent, often strikingly unimpressed by my interpretive efforts. They didn’t seem to want to develop an intensely dependant relationship.

Perhaps I simply hadn’t figured out how to do it right. I read and reread Winnicott and tried to maintain the stance I imagined was his. But it didn’t work. Facing a disjunction between my therapeutic vision and the actuality of my personhood, I reluctantly admitted the limitations of the Winnicottian archetype. How could I reconcile this divergence and find an analytic model that would better suit me and the reality of the clinical encounter?

The work of contemporary psychoanalytic writers including Ghen, Mitchell, Aron, Benjamin, Harris, Hoffman, and Davies provided a rich alternative. I began to envision a new way to enter analytic process that integrated Winnicottian and relational thought. I could aim to be responsive and contained without denying or excluding the impact of my subjectivity on the dyadic mix. No longer attempting to don a separate set of therapeutic clothing that left central aspects of my personhood outside the consulting room, more of me was in the mix. I seemed to have set aside my more ambitious professional aspirations in both their Freudian and Winnicottian manifestations.

Or was this an alternative ideal, a new “analytic noir” genre? Had I jettisoned the analyst—myself—as a romantic figure or inadvertently concealed romance beneath the surface by recasting the analyst as an antihero?

On one level, relational thinking has rejected the heroic analytic archetype organized around professional authority, objectivity, power, or maternal bounty (Grond, 2003). Yet the analytic archetype hasn’t disappeared; instead, it has morphed into a new shape, a partial silhouette of the former that valorizes the analyst’s subjectivity. This is a vision of a nonauthoritarian, emotionally open, uncertain analyst who’s content with what is—messy, multifaceted realities—who can express herself comfortably and openly. It is, in some respects, as imaginary and ideal an analytic position as were those of earlier eras.
Psychoanalytic visions

Psychoanalytic ideals are visions of how we should function in the treatment situation. These visions organize the work, give us ground to stand on, and reassure us that we’re performing well (Friedman, 1988). Even when unrealizable, they represent goals that serve to structure and stabilize self-experience and behavior. Professional ideals amplify our sense of therapeutic (and personal) potency, allowing us to enter the treatment space with more determination than anxiety. They point to the future and give life meaning (Kohut, 1971, 1977, 1984).

Ideals are often both galvanizing and inspiring. They may act as a crucial signal, an inner reminder of the risk of professional lapses that helps us steady ourselves (see Chapter 4). Cooper (2000) discusses notions of hope and hopefulness contained in different analytic theories. Our theory helps us persevere in what is, more often than not, an ill-defined and uncertain process. As an outside element within a complex relational framework, ideals can provide reassurance that we’re doing what we should be doing. And when the work seems to be going badly (or not at all), ideals may help us sustain a positive image of ourselves.

The analytic ideal inhabits some of the same territory as Freud’s (1914a) ego ideal, a vision of personal perfection that coalesces when the child confronts the limits of narcissistic omnipotence. It becomes a model toward which to strive (Chasseguet-Smirgel, 1976). These visions, organized around the desire to help our patient, become embedded in a series of (culturally and personally derived) dos and don’ts that sometimes occlude their source—the idea that we’re in the business of helping people.3

Freud’s (1912) descriptions of the analyst as surgeon, detective, or archaeologist evoke images of penetration and depth, of “cracking the code.” The surgery metaphor emphasizes the analyst’s ability to remain objective and unsparing in her attempt to cure (Stepansky, 1999). The analyst isn’t emotionally embroiled with the patient; she’s sufficiently detached to focus exclusively on the therapeutic task at hand. She interprets, even inflicts pain when necessary, with the aim of offering penetrating insight (Blum, 1981). The detective finds and links dynamic clues that elude the patient entirely. The archaeologist digs deep, sifting rubble from valuable finds and identifying the latter with precision and certainty.

In later years, Freudian metaphors (used in different ways by Freud and others (see Chapter 2) gradually softened and became complicated by other theoretical viewpoints. As the value of the analyst’s emotional responsiveness was recognized, parental metaphors (maternal and paternal) were formulated. The analyst as mother/father now had a place in the analytic world: British object relations theorists saw in analysis an opportunity to relive and rework early trauma, a process requiring a calm, emotionally responsive, and containing analyst. Indeed, Winnicott (1954b) invoked the Freudian model to illustrate not the analyst’s objectivity, but her capacity to create a stable and reliable holding environment. Other writers (e.g., Le Guen, 1974) began to emphasize the analyst’s benign paternal function as a wise and kindly interpreter.

Schafer (1983) offers us a more explicit vision of the “analytic attitude,” an attitude that’s at once human and ideal (despite his explicit warning against idealization). The analyst is capable of maintaining a position of emotional acceptance wherein “nothing human is alien to me” (p. 46). This stance is enormously appealing in its humanity.

Yet it’s also idealized: the analyst takes a far more patient and accepting position than can be sustained in ordinary life. Schafer seems to sense the difficulty, even the improbability, of this exigence and coins the term “second self” to describe the analyst’s functioning in this ideal mode.

Depending on the analytic metaphor to which we’re drawn, our professional aspirations will take different shapes. But whether we aim to be profoundly human and profoundly accepting, deeply interpretive and penetrating, interpersonally confrontational and nondefensive, or mirroring of self-experience while we set ourselves aside, these aspirations are inherently unreachable and potentially daunting. All are psychoanalytic archetypes, visions of ourselves as simultaneously human and fantastic. And whichever version of this theoretical ideal we embrace, we exclude or minimize those aspects of our humanity that clash with our vision—our vulnerability, problematic reactivity, or the power of the subjective.

Glick (2003) describes the problematic professional implications of his early, idealized role models. Dimen (2001) coins the term “Real Analyst” to describe our collective experience of not quite being one. We’re all vulnerable to feeling not up to par, or fake: “Not an actual person, the Real Analyst is more like a totem, the founder of a lineage” (p. 2). Unlike us, the Real Analyst never questions her legitimacy and is never questioned. And so while they inspire, analytic ideals can also make it difficult for us to question ourselves and breach the particulars of our chosen frame. They must be, at least in part, outgrown if we’re to develop our own distinctive style and authority.

The psychodynamics of theory choice

Every analyst and every analytic generation embraces a particular theoretical ideal that’s informed both by the psychoanalytic culture and personal dynamics. Many of us have a desire (conscious or unconscious) to reverse previous analytic (and parental) failures in our role as helper. We long to do it better—to be more responsive, understanding, interpretive, or wise—than our parents or analyst.

But our choice of theory may also reflect the cultural/political climate of the time. For example, many of us who have embraced contemporary models came of age in the counterculture of the 1960s. We value egalitarianism; we
tend to squirm a bit when our patients declare us powerful or omniscient. Adding to this resistance may be our own quite traditional first analysis. I suspect that our desire to be human and fallible is as completely derived as was the need of earlier generations to maintain a distant, authoritative stance.

As I discuss in Chapter 2, some of us are deeply identified with our professional role models while others, hoping to create a more satisfying alternative, react against those models. At times, professional aspirations organize around a disidentification, an ideal in negation. Here, the psychoanalytic other represents a “bad-analyst” position and professional goals form as its oposite.

Theory, then, isn’t divorced from the personal: the two threads interpenetrate. A careful examination of our particular analytic vision will reveal a complex intermixture of theoretical ideas, personal needs, and wishes.

Robert, now a successful analyst, was the only child of an early and bitter parental divorce. He grew up with his rigid, rule-bound father whose world was one of “shoulds” that communicated to Robert that his father held the single key to proper living. Robert identified with his father’s need for order and located its source squarely within the parental domain. Despite some significant ways in which Robert resisted his father’s self-righteousness, he unconsciously embraced the belief that his father really did “know best.” (Not altogether surprisingly, the American television serial “Father Knows Best” was among his favorites; Robert longed to be the son of the kindly, bumbling, but still authoritative father depicted therein.)

Perhaps the most painful consequence of Robert’s early experience was a deep feeling of inadequacy. Robert remained unconsciously convinced that had he embraced his father’s rules for living, all would have gone well. But Robert also resisted collapsing into compliance. Simultaneously longing for recognition and protesting against his parents’ emotional obtuseness, Robert insistently expressed his unhappiness. In doing so, he held on to himself and maintained his self-integrity, but at some cost; he often felt like a sullen, woeful child.

Robert was unaware of an underlying fear that he was greedy and bad. Longing for a parental connection, Robert attacked himself while simultaneously feeling hurt and angry at his father for his controlling, rejecting stance. Robert’s ability to maintain contact with his wish for intimate contact probably protected him from the excessive use of dissociation and splitting as a way of managing painful affect. Nevertheless, the longing for a reparative parental relationship remained strong and Robert entered analysis in his early twenties. In that treatment, he came to recognize the destructive impact of his father’s controlling and moralistic stance and gradually developed a more shaded picture of himself that included his many competencies. But Robert continued to struggle to sustain a sense of worth rather than locating value in the (paternal) other (in part represented by the male analyst he idealized).

Like many of us, Robert entered the field of psychoanalysis hoping unconsciously to redress and reverse painful relational dynamics. Becoming an analyst allowed Robert to enact the need for a different parental connection—he would offer his patients (and thus symbolically receive) the sensitive attention and responsibility for which he longed. Not surprisingly, Robert envisioned himself as a powerful paternal analyst, a particularly effective antidote to early experiences as a helpless, needy child.

During the first years of his analytic career, Robert contended with the fear that he was “faking it”—that he was closely scrutinized, his inadequacies would be revealed. His father could know; he couldn’t. But that anxiety gradually gave way to a deepening belief in his own competencies: two decades later, Robert can reliably access and sustain a comfortable analytic self-image. The professional ideal that has taken shape in part reflects his identification with his analyst and his favorite supervisor. Robert has also been influenced by interpersonal theory and self psychology, two perspectives that inform his gently confrontational style.

Robert’s professional ideal is thus theoretically derived and dynamically driven—merged with a vision of an analyst/parent who can “do it just right.” I want to underscore not the pathological dimension of Robert’s use of the ideal, but, rather, its complex origins and functions. When it’s engaged, Robert feels gentle, wise, and emotionally powerful, able to steady himself and sustain a thoughtful therapeutic posture. That posture symbolically reverses his parents’ failures without altogether negating his own vulnerability. It’s a theory that inspires and guides him; but while it has its own legitimacy, it’s informed by the personal. And I think this is true of us all.

Contemporary psychoanalytic visions: a softer ideal?

To some extent, contemporary psychoanalytic visions soften the power of the ideal. Our understanding of the analyst’s role is both more shaded and complex than it was; we’ve rejected some of the unreachable aspirations of earlier psychoanalytic models and we’ve freed from some of their constraints. We can’t “know” what our patient feels, nor should we attempt to simply become a wise or reparative object (e.g. Dreyfus, 1978; Hoffman, 1983, 1991; Hirsch, 1987, 1992; Mitchell, 1988, 1991b; Aron, 1991; Casement, 1991; Jacobs, 1991; Burke, 1992; Tansey, 1992; Levenson, 1994). This flexible, multilayered, and multifaceted perspective resides at a more meta-psychological than technical level. In many respects, it offers us a new set of therapeutic guidelines that are both liberating and organizing. They relate not so much to what we know or do but to a particular emotional and intellectual position characterized by openness and a willingness to tolerate paradox and uncertainty.

Contemporary analytic ideals aren’t technically prescriptive: though the psychoanalytic book hasn’t been discarded, it’s no longer used as a bible
vision of analytic authority. We defensively evade self-doubt; we can't tolerate the possibility of an analytic error or a nonuseful enactment. And while we need to study and question why we can't tolerate not knowing, I don't believe that we can always theorize our way out of those needs. We're no more capable of sustaining full emotional engagement and ongoing introspection than we were of objectivity and neutrality.6

Consider this version of the relational ideal, articulated by a senior colleague during a conversation about this chapter:

I want to use myself as an emotional instrument, tuned into my patient and myself. I use myself, my feelings, and bodily sensations to inform my work. I believe I am always involved with my patient, I'm never an observer. When I have a strong reaction, when I feel angry, sad, excited, I study my experience and use it analytically. I enjoy becoming caught up with my patient, working my way out of enactments. My failures are useful; they move things forward. I'm not aiming to be perfect, because it's my imperfections that are key.

In many respects, this analyst's view of herself as an emotional instrument (see Isakower, 1992) is inspired. It establishes an organized, idealized therapeutic position toward which to strive. But it also creates another, perhaps equally unrealistic, professional ideal.

Analytic ideals and analytic authority

For some of our patients, our egalitarian frame, open humanity, and uncertainty offer a powerful repair in their own right. There's room—to look inside for answers, question authority, engage in a kind of mutual interaction that may have been nearly (or absolutely) missing until now. Yet there's a risk here too: the contemporary ideal can leave us (or our patients) feeling as if we were standing on weaker and shorter legs. Some patients may resist attempts to democratize the relationship by unconsciously—or explicitly—insisting on our omniscience.

Tom, who grew up in the home of laissez-faire parents who set few rules, allowed him very wide latitude to make his own mistakes and encouraged him to question authority, doesn't want a relational analysis: he's in search of an antidote to uncertainty. Tom wants his analyst (whom I supervise) to have a blueprint for the treatment, set rules and keep them, define and interpret with certainty. Relational engagement and analytic uncertainty remain his therapist's goal, but at least for now, they're unreachable.

Analytic authority may be a partial fiction, but for some patients it's a vital one. Like the illusion of self-sufficiency or attunement, an illusion of analytic authority sometimes provide a crucial layer of protection. Can we question
our own authority and still leave open the possibility that at moments we may need to embrace it?

Collisions and convergences: self-interest and the visionary

Analytic visions reside at some distance from the ordinary, from the messy reality of our moment-to-moment functioning or the invasion of our self-interest (conscious and unconscious) into the work (Slavin, 2000). On one level, the professional ideal exists in tension, indeed in potential collision, with our personhood. This tension exists independent of the particular ideal to which we subscribe (see Chapter 4). When we bifurcate the personal and professional, we create a clash between two core yet often opposing pulls.

But can we, in fact, separate the professional from the personal? To the degree that we embrace a professional ideal, the personal infuses the professional. What originates as an externally derived model of how to function is gradually assimilated into the arena of personal need. By embracing our analytic ideal, we sustain our own “good-analyst feeling” (Epstein, 1999); we need to be good analysts, to set aside those aspects of ourselves that interfere with the work. An excessive emphasis on the tension between the desired and the actual may obscure the interpenetration of these two themes and create another ideal.

I’m suggesting that the analytic ideal contains and expresses the personal. It may provide a therapeutic repair for our personal issues, express our need for—or resistance to—authority, disidentification with a punitive, withholding, or withdrawn parent. Alternatively, our ideal may reflect an identification with parental vulnerability, emotionality, or impotence. It may reverse core unconscious dimensions of self-experience, symbolically repair a malignant or parental introject. To name a few.

Of course, the professional ideal doesn’t always act as a support (Hoffman, 1998). When our image of psychoanalytic work functions as a severe superego, we’re less likely to feel inspired than guilty or ashamed, pulled toward defensive denial or humiliating failure. Negatively valenced self-states are split off or disavowed; bad self-experience is projected outward, or, alternatively, turned inward in an orgy of self-attack. As the capacity for reflectivity narrows, our thinking rigidifies; inner struggle and dialogue are foreclosed (Davies, 2004). Benjamin (2004) notes that this kind of vicious self-scrutiny cannot be stabilized in the moral third: “Analytic ideals simply become a punitive form of scrutiny, a shaming judgment that collapses the space of thirdness inside self and between self and others” (p. 752).

Linda’s defensive use of a professional ideal contributed to a disastrous treatment failure. Her analytic self-image was organized around her capacity to function empathically and meet her patient’s self-object needs. Engaging her ideal as a personal guide that helped her organize her thinking, Linda worked easily and well within this framework. Her self-esteem was tightly bound up with the need to be good, a need that was reinforced by a model that emphasized the mutative function of empathy and working through of self-object failures.

As long as Linda felt that she was helping her patient, she satisfied her ideal and functioned well. However, Linda ran into trouble with Jane, a patient who began to experience her as withholding and rigid. Although Linda initially attempted to respond empathically to Jane’s hurt, Jane didn’t experience Linda’s attempts as soothing and instead felt Linda to be unresponsive. As Jane became increasingly distraught, Linda felt under fire and was unable to access a good-enough analyst feeling (Epstein, 1999). In an attempt to protect herself from attack, Linda rigidified. She couldn’t tolerate this threat to her professional self-esteem by taking seriously Jane’s need for her to genuinely explore how she was failing. Increasingly, Linda used her professional ideal as a shield that protected her from self-reflection. She desperately held on to the belief that she knew what she was doing, that Jane was trying to destroy the treatment. Linda was unable to examine her own experience of collision, and the treatment ended abruptly and traumatically.

When we can’t tolerate the discrepancy between the ideal and the actual, we have few good choices. Persecutory anxieties become lodged in the ideal; the smallest professional misstep represents a profound personal failure. To manage these pressures, we may attempt to deny our failure or locate the ideal in the prowess of the other, better analyst.

As I discuss in Chapter 2, it’s not uncommon for supervisees to feel chronically inadequate as compared with their supervisors, in whom they locate the desired analytic posture. But even senior analysts may harbor the fear that they don’t quite measure up—that they’re insufficiently wise, emotionally present, or capable of penetrating insight.

Our ideals and our failures

When we find ourselves functioning in ways that seem impossibly far from the ideal, we confront a moment of collision. These collisions may be temporarily disruptive or permanently shattering.

Nat, an older colleague, recently experienced the unexpected and untimely death of a beloved sibling. He’s in a state of acute traumatic mourning, buffeted by intensely fluctuating affect states, flooded, and at some remove from his patients and himself. Nat is acutely conscious of the gap between the warm, confident presence that he offers his patients and the subjective “reality” of his vulnerability and depression. Although at times he finds himself shifting into a more solid analytic self-state, at other moments he feels unreal, more like an actor than he would like. Nat experiences a powerful clash between his professional ideal and his intense emotional reactivity. He wonders if he’s doing his patients a disservice, creating the pretense of being fully present when, in fact, he’s not.
In part, Nat minimizes the genuine, positive shift that takes place when he “becomes” the analyst, for in that context, he experiences a more integrated sense of self—that of a working professional. Yet there’s also a measure of real affective absence that compromises Nat’s ability to function and confronts him with his failure to meet his professional aims. As Nat contends with a disturbing sense of inner disequilibrium, he struggles to encompass the discrepancy between his actual and visionary analytic self, rather than abandoning either.

It’s not always easy to recognize the space between our aims and our personal limitations (whatever their shape). When we experience ourselves as unacceptably far from the professional position we aim for, we may respond with a feeling of inner collapse, an abandonment of our therapeutic position. Awareness of failure breaks up a positively valenced professional self-image; we’re filled with self-reproach and sometimes shame. The desired, good-analyst position is externalized, located outside the self. In an attempt to assume that position we run the risk of losing contact with our own therapeutic idiom.

Sarah, an interpersonally trained analyst, read a book by a contemporary Kleinian who advocated working deeply and interpretively in the transference. That position contrasted sharply with Sarah’s interpersonal, interactive orientation; Sarah became aware of the collision between two discrepant professional ideals—the Kleinian and the interpersonal. Already struggling with self-doubt about her analytic acumen, Sarah became convinced that the Kleinian perspective was the “better,” “smarter,” “deeper” way of thinking and working. Sarah responded to her anxiety by disidentifying with her own professional model.

One day, a patient brought in a dream and Sarah became flooded with a feeling of inadequacy. Facing the disintegration of her own professional vision, Sarah made a Kleinian interpretation. In doing so, Sarah skipped over her patient’s specific vulnerability and defensiveness about addressing transference issues. She ignored the collision of the Kleinian model with the theoretical perspective in which she had been working and temporarily disrupted the treatment relationship.

Sarah’s self-doubt and secret belief that other analysts were far superior to her were intensified when she had to face a divergent ideal. Momentarily abandoning her professional identity and embracing an alternative analytic model, she lost contact with her patient’s emotional state and her own strong identification as an interpersonal analyst.

Although Sarah’s self-doubt sometimes undermined her capacity to sustain herself during the clinical hour, it also propelled her to question her ideal and entertain other ideas and clinical perspectives. Over time, Sarah has become more conscious of this process. She’s increasingly able to engage playfully with alternative ideals and use them to expand her clinical perspective without anxiously and unreflectively abandoning her own way of working.

Our analytic ideal is influenced by the particulars of the relational encounter and shifts in the overarching theoretical ambiance to which we’re exposed. In part, we construct our ideal with our patient, as our shared needs for a particular therapeutic vision coalesce.

While most of us develop and gradually refine a therapeutic posture and treatment ideal, that ideal expands or shifts with time as we encounter new theoretical ideas and clinical situations. Some of us stick as closely as possible to a single model, whereas others engage an interrelated range of theories depending on what we believe a given patient needs. In work with intensely distressed, angry, or demanding patients, for example, we may embrace a vision of a resilient, containing analyst; in work with a vulnerable, traumatized patient, we may turn to a maternal analytic model.

Patients also have analytic ideals, visions of how and who we should be. The ideal analyst may be authentic, emotionally open, all-knowing, endlessly patient, empathic, reparative, incisive, or perfectly objective. Some people hold these ideals lightly; they retain an awareness of their paradoxical qualities, while others cling rigidly to them. They enter treatment gingerly, hoping against hope or warding off despair (Mitchell, 1993); the notion of an analytic vision exists in constant tension with an awareness that therapeutic process is fragile and vulnerable to collapse.

We pick up, resonate with, and react to our patients’ visions. At times, experiencing ourselves in the professional halo colored by shared needs and beliefs, we and our patient establish a coconstructed therapeutic vision. At other times, our patient may be unable to sustain belief in the ideal; we move reflexively to counter that absence by invoking a compensatory ideal in an attempt to create a sense of hope or to ameliorate self-doubt (see Chapter 8). At still other times, we experience those same illusions as jarring and ego distonic; we resist them by stubbornly holding on to the reality of our nonideal subject-hood.

When a patient’s ideal clashes with our own, we experience a different kind of collision. Our patient, for example, may envision an analyst who can provide immediate relief, whereas we believe that only an inner shift will produce lasting change (London, 1964). Or our patient may imagine an analyst who’s eternally omniscient, a view that clashes uncomfortably with our own preference for, and belief in, the therapeutic function of mutuality. We struggle against the dual possibilities of submission and defensive resistance as we attempt to negotiate a space between the two.

Clashing ideals create tensions between patient and analyst, but those same forces can also create a new analytic vision. This is a mutually constructed ideal that’s grounded in a jointly established, conscious, and unconscious understanding of how we want to function with a given patient.
It's perhaps, in a third space (Ogden, 1994) that the separate ideals of patient and analyst are transformed in ways that more closely approximate the specifics of that treatment relationship. This new ideal becomes the analyst’s (and the patient’s). It's informed by the therapeutic couple's joint experience, to be used, reshaped, and perhaps even abandoned over the course of their work together.

Over the course of an analysis, our professional ideal may shift in response to changes in the shape and affective tone of the treatment. In part, these shifts are conscious: we readjust our clinical assessment of our patient’s issues and needs, and our professional vision adjusts as well. Yet, on another level, the professional ideal resides at a more implicit than explicit level and we may not be altogether aware of its changing shape.

Harry entered treatment because of work-related problems that organized around his tendency to protect his self-esteem by denigrating those around him. There was some urgency to his job situation and I worked in a fairly confrontational way, trying to break into the contempt that dominated and sometimes destroyed Harry's relationships. In doing so, I engaged the intersubjective dimension of my analytic ideal: I used myself as I tried to help Harry recognize how reflexively he demeaned the other (including me). I directly addressed the nature of our interaction and consciously accessed the relational ideal as I worked.

Although Harry reacted somewhat anxiously to my confrontational stance, his relationships improved dramatically and his defensive denigration began to give way. Lacking a ready solution to his own self-doubt, Harry became conscious of previously dissociated feelings of shame and inadequacy. His vulnerability was now palpable.

I responded to Harry's more obvious feelings of fragility by shifting out of a confrontational stance and into a more containing, empathic position. This clinical move seemed more intuitive and organic than deliberate. However, in writing about this work, I became aware that I had begun accessing a different professional ideal with Harry. I moved away from an interpersonal psychoanalytic vision and toward one lodged in my ideas about the analytic holding function. I wanted to create space, to help Harry contact and work with painful feelings of vulnerability without reverting to self-protective grandiosity.

My shifting analytic ideal was embedded within and outside the relational mix. It emerged out of my assessment of Harry's need, my own emotional (not always conscious) response to our way of being together, and perhaps also to Harry's unarticulated romantic fantasy about psychoanalysis. Initially, he yearned for a strong, guiding parental figure. More unconsciously, he replayed aspects of his relationship with his critical father with me. I suspect that my confrontational stance was informed both by my clinical ideal and unconscious identification with this parental introject. Later in the treatment,

as Harry contacted the vulnerability underlying his arrogance and a fantasy of being held by a more understanding parent, my stance softened and I accessed a version of the Winnicottian ideal. On one level, this shift occurred in response to my reassessment of his therapeutic needs; on another, it reflected the changing shape of our interaction.

Most recently, Harry has begun to link his chronic suspiciousness to an underlying vulnerability to rejection. It's now possible for him to acknowledge his anger and need for me, and I find my professional ideal shifting once again. Following a chance encounter on the street, I told Harry, with some trepidation, about my reaction to his vaguely menacing look. I pushed beyond his initial defensiveness and somewhat confrontationally invited Harry to think about how others experience him. My analytic ideal had shifted once again, this time in an intersubjective direction.

Over a professional lifetime

Over the trajectory of our analytic career, we absorb a variety of theoretical and personal influences; those influences are integrated and subjectively located within (Slochower, 2004, 2014). Accumulated clinical experiences and new theoretical ideas reshape our sense of ourselves and our goals, which become increasingly multifaceted.

Time typically solidifies our sense of professional self-esteem; we become less buffeted by inner and interpersonal pulls, more comfortable with our theoretical identity. The space between our goals and the actuality of self-experience in the consulting room narrows; the professional ideal becomes more flexible and inclusive while our analytic self-esteem is less vulnerable to shatter. More solidly living in our own theoretical and personal skin, we find it easier to tolerate and embrace a complex analytic model, to envision a way of being without feeling demoralized when we fail to meet it.

For other analysts, though, time rigidifies the analytic ideal until the analyst finds herself trapped in a world of professional dos and don'ts. Clinging to ossified, rigidly held guidelines, she uses her ideal as a professional blueprint that replaces the personal and leaves her outside the dyadic arena. In my experience, this dynamic can occur independent of our particular orientation. Classical technique can become fossilized into a caricature of analytic neutrality; relational or interpersonal technique into an insistent process of confrontational moves or self-disclosures, self psychology may become reflexive empathy. And so on.

Conclusion: an ethical psychoanalytic vision

Analytic ideals support our professional commitment but they also serve personal needs. And while our visions sometimes clash with other aspects of our personal agenda, the two dimensions also inform each other. It's in our
own professional interest to become the best analyst we can; in this sense, the “ideal” is also the “needed.”

Psychoanalytic collisions are unavoidable. They disrupt by confronting us with the tension between the ideal and the actual, with our professional limitations (Abend, 1986). None of us consistently sustains our analytic vision across the professional lifetime. At times, we all—new candidates and senior analysts—will fail our patients. Some failures will seem inevitable; some we’ll blame ourselves (or our theory) for. Our theory collided with our personhood and we went the wrong way. We were too rigid; too open; too dense; too interpretive; too quiet. We kept our patient in treatment too long; we gave up too soon.

Yet despite all this, I want to make a plea for the retention of a single overarching commitment—that of an ethical analytic identity organized around the aim of helping our patients above all. It’s an ideal that requires that we own and study our failures rather than allowing complicity to reign. It means tolerating self-doubt, pushing past defensiveness to examine what went wrong, how we’re implicated in those bad moments; it means being willing to change course rather than rigidifying because our patient is more important than our theory, our rules, or our needs.

I actually think that many of us own our failures more easily than we own our successes. This can be true whether we succeeded by sticking to our analytic rules, temporarily throwing them away, or moving in a third direction.

Yet you usually know when you’ve helped. A man haunted by decades of abuse, and the hate and self-hate it generated plunges into an intense, sticky, and often painful analysis punctuated by moments of traumatic reenactment. He volleys from hope to misery and back again; too often you’re the new abusive object and struggle to tolerate feeling hurtful without withdrawing or defending yourself. But you and he stick it out; a decade of hard, relatively traditional analytic work goes by and one day you realize there’s been a seismic shift. He has made a life for himself, no longer lives under the specter of his father’s belt and fists. He acknowledges all you’ve done and the two of you cry together.

A couple brings a lifetime of bitterness into the office; week after week they seem intent on destroying one another and they decimate your therapeutic efforts. You try everything but nothing seems to work for long. Finally, out of desperation, you move out of your ordinary therapeutic chair; you talk to them about life’s limits; you lecture, exhort and even plead; you pull rabbits out of hats. And one day you reach them; they soften and start to make something better between them. There’s no drama to this change, but hope has turned up where before there was only despair. You don’t exactly take credit for all this because, of course, it took two—you and your patient—but it’s important to take a little credit anyway.

If you’re to sustain an ethical psychoanalytic vision over the years, you—we all—need to embrace successes like these along with a willingness to examine our failures. Both demand that we continue to study ourselves. We need to sustain a commitment to self-examination across the lifetime even though it collides with so many things—the contemporary cultural ideal, moments of selflessness, clinical fatigue.

Sustaining an ethical psychoanalytic identity is tough to do alone. I hope that the privacy (and aloneness) of the consulting room is balanced by some inspiring psychoanalytic models you idealize a bit—the theory or theorist you’ve embraced, but also supervisors, your analyst, teachers, friends, and colleagues. We all need to have an internal guide as a steady, symbolic force in troubling moments. And we’ll need at least some of those models to really be there, available to us when we’re in trouble, when life, death, or illness gets in our way.

We all need lots of help addressing the disturbing ethical issues our field confronts, issues that collide with the professional ideal; they disrupt us at the individual and institute level and they undermine the field as a whole. Nothing seems to me more central to sustaining an ethical stance than a renewed commitment to privileging our patient’s needs over institute loyalties and politics, self-interest, over social anxieties.

And so I end this book, as I began it, with my mother. I lost her before I could tell her many things, perhaps none more important than how much wisdom and complexity guided her life and informed her simple statement of psychoanalytic purpose. It’s really her wisdom that I offer to you, the reader: whatever the particulars of your psychoanalytic theory, find and hold firm to the ideal inherent in the business you’re in, one that demands that you help people above all. Study, question, doubt. Sustain and model an ethical stance when other kinds of considerations—expediency—would compel you to close your eyes, look the other way, remain silent. Enact that ideal as you offer yourselves, your wisdom and care, to your patients. Because this is the business that you’re—that we’re—in.

Notes
1 At other times, we act first and theorize later, accessing a professional ideal that supports (or justifies) our clinical work.
2 See Sandler et al. (1963) for a discussion of the vicissitudes in Freud’s conceptualization of the ego ideal.
3 Therapeutic goals vary widely. They include facilitating structural change (Freud, 1916), achieving the depressive position (Klein, 1950), achieving more adaptive compromise formations (Brenner, 1976; Abend, 2000; Bergmann, 2001), the possibility of a new beginning (Balint, 1968), an ability to play and engage in object usage (Winnicott, 1971), experiencing the analyst as a new object (Loewald, 1960) and gaining an improved capacity for narcissistic regulation (Kohut, 1971).
4 Contemporary theories have introduced additional treatment goals into the psychoanalytic paradigm that are more in keeping with these ideas. These include
the integration of dissociated affect states or split-off parts of the personality (Bromberg, 1994, 1998; Berman, 2001; Mitchell, 2001; Renik, 2001); better balance between self- and interactive regulation (Beebe et al., 2003); a deepened capacity for intersubjective relatedness and mutuality (Benjamin, 1995; Aron, 1996).

5 Mitchell (1997) notes that contemporary analysts have a different kind of authority because they can “justifiably claim an expertise in meaning making, self-reflection, and the organization and reorganization of experience” (p. 204).

6 Kraemer (1996) notes that contemporary writing on motherhood recognizes the mother’s ubiquitous subjectivity. What tends to be ignored, however, is the unresolvable clash between the baby’s and mother’s needs (Dinnerstein, 1976; Chodorow, 1978; Benjamin, 1988; Chodorow et al., 1989; Flax, 1990; Bassin et al., 1994). The mother cannot always meet both her own needs and her child’s; her separate subjectivity will inevitably result in collisions of need. It’s not a given that these collisions can be usefully assimilated by the baby.