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Six things worth understanding about psychoanalytic psychotherapy

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This paper is written for family therapists who may be curious but sceptical about psychoanalysis and psychoanalytic psychotherapy. It examines a number of areas of misunderstanding within mainstream family therapy discourse (diversity, authoritarianism, terminology, blame, history and separation) which, the author believes, have acted to help maintain a false coherence for family therapy through a distorted construction of the otherness of psychoanalytic therapy and, in so doing, inhibited a potentially more productive relationship.

Introduction

The first volume of the *Journal of Family Therapy* in 1979 records a high watermark of psychoanalytic thinking in family therapy in the UK with both the editor, Christopher Dare (1981, 1988), and many contributing authors having analytic interests (Bentovim, 1979; Box, 1979; Byng-Hall, 1979; Cooklin, 1979; Dare, 1979; Lieberman, 1979; Skynner, 1979). At that time, the developments in object relations theory and group analysis in this country were well placed to make a major contribution to family therapy thinking. Structural and strategic family therapy models – which tended, at least implicitly, to be written against psychoanalytic thinking – had yet to achieve their sweeping dominance of most of the 1980s. When these models in turn were superseded – at least in the mainstream – by Milan and especially post-Milan second order family therapy there was no return to the same level of interchange with psychoanalytic ideas despite the original Milan associates being analytically trained.

It is, perhaps, paradoxical that, given the dominant narrative and social constructionist developments in family therapy over the past decade, there has been a growing minority interest in the possibilities

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for enrichment of family therapy through re-engagement with psychoanalytic thinking (Bertrando, 2002; Donovan, 2003; Flaskas, 1996, 1997, 2002; Frosh, 1995, 2002; Jenkins, 2006; Johnsen *et al*., 2004; Kraemer, 2002; Larner, 2000; Leupnitz, 1997; McFadyen, 1997; Pocock, 1995, 1997, 2005; Schlicht and Kraemer, 2005; Speed, 1999, 2004; Woodcock, 2000). What may have changed in the therapy world over the past ten years to make this possible?

- Family therapy is more securely established and does not need to draw such clear distinctions with its neighbours. (Professionalization and the role of the United Kingdom Council for Psychotherapy are relevant factors in the United Kingdom.)
- 'Systemic' is no longer a single overarching theory (or metanarrative) for family therapy now that family therapy has incorporated narrative and social constructionism and other big ideas which are not obviously related to systems theory.
- Working with an individual is more acceptable in family therapy for the same reason as above.
- Family therapists are now becoming as interested in internal processes (such as personal narrative) as they are in interactional ones.
- Attachment theory and parent–infant research are growing bridges between family therapy and analytic psychotherapy.
- Understanding, not-knowing, reflexivity and making sense together are common reference points.
- Postmodernism either explicitly or implicitly makes the drawing of tightly boundaried therapeutic models less supportable.
- The notion of an at least partially knowable reality 'beyond the text' is rapidly gaining ground again (but without any return to positivism or naive realism) in a number of academic circles through the influence of critical realism (e.g. Bhaskar, 1998).
- Both psychoanalysis and family therapy have expanding evidence bases.
- Psychoanalytic ideas continue to spread beyond the consulting room.
- Psychoanalytic psychotherapy is more pluralistic.
- There are specific major developments in psychoanalysis – especially in American psychoanalysis – which, to some extent, are

either parallel or complementary to those of family therapy (e.g. relational psychoanalysis, intersubjectivity theory and narrative developments).

In the UK, psychoanalysis, when used as a clinical description, generally refers to work of four or five sessions per week undertaken by those who have qualified in a small number of (mostly London-based) training establishments. Psychoanalytic psychotherapy generally refers to work of a frequency of one to three sessions per week and training is offered by a broader number of institutions. This distinction does not exist in the same way in North America where both are called psychoanalysis. I think there are differences between the two (especially noticeable between once per week and five times per week) but these are not easy to tie down. Psychoanalysis also has a non-clinical meaning when used to refer to academic interests in these ideas. These are prominent in discussions of social and cultural theory.

I will use the word 'psychoanalysis' to refer broadly to all clinical and non-clinical applications of psychoanalytic ideas and I will use the term 'psychoanalytic psychotherapy' and, to ring the changes, the terms 'analytic psychotherapy' or 'psychoanalytic therapy' to refer predominantly to clinical work with individuals.

I am using the term 'family therapy' in a broad inclusive manner to encompass a loose collection of ideas drawn largely, but not exclusively, from three major theoretical roots – psychoanalytic, systemic, narrative/social constructionist. Although, in my work with individuals, I practise as a psychoanalytic psychotherapist (an eclectic one) I should add that in my family therapy I do not identify myself as a psychoanalytic family therapist. Rather, I prefer to see myself as an eclectic family therapist who feels that many psychoanalytic ideas have much to offer.

In this paper I have chosen six things that family therapists who are curious but sceptical about psychoanalysis might find worth understanding. In doing so, I am trying to correct some common active misunderstandings about individual psychoanalytic psychotherapy which are implicit in family therapy. I notice these all the time because they make me wince but if I am with a family therapy audience I notice that other people often do not wince – such misunderstandings being accepted and therefore not noteworthy – within some parts of family therapy culture. Here is an unusually explicit example from a chapter by Gergen and Kaye (1992, p.172) in their book *Therapy as Social Construction*.

> [P]sychoanalysts who question the foundations of psychoanalytic theory are placed in professional peril. Under these conditions the client confronts a relatively closed system of understanding. It is not only that the client's own reality will eventually give way to the therapist's, but all other interpretations will also be excluded. To the extent that the therapist's narrative becomes the client's reality, and his or her options are guided accordingly, life options for the client are severely truncated.

I used the term 'active misunderstandings' earlier and, by this, I am referring to the *effect* of these beliefs, or – in postmodern jargon – how these beliefs perform. They seem to position psychoanalysis as a discredited outsider. For example, in the above quote – through making psychoanalysis the authoritarian and brainwashing other – it becomes self-evident that the reader should stand firmly on the constructionist side of the constructionist/psychoanalytic border; the side marked 'moral high ground'. This form of rhetoric both reinforces the constructionist territory and reassures those within it that they need not worry so much about authoritarianism. The implicit messages are 'We're not like them', 'Relax, you're one of the good guys' and 'Don't go over there – they're so bossy and controlling'. So, in my view, these misunderstandings help to create an identity for family therapy; an *us-ness* defined by the *them-ness* of psychoanalysis (see Kraemer (2002) for a fuller discussion). These processes are common to all groups and cultures, and occur also from time to time *within* family therapy (e.g. first order vs. second order, narrative vs. systemic, and narrative vs. solution-focused therapy). Psychoanalysis (Klein, 1935) calls this splitting; Gregory Bateson (1972) schismogenesis; and Michel Foucault (1975) disciplinary power.

But why bother to understand more? Why should psychoanalytic psychotherapy be of interest to family therapists? In my view, for three reasons:

1 Therapists have, I believe, a primary duty of care not to be analytic or systemic or narrative but to be helpful. (I note here that this term is necessarily loosely defined when speaking of it as a generality since helpfulness cannot be defined independently of those seeking help.) But helpfulness, I think, must be a higher ethic than professional identity. I believe that some clients or patients can be helped best by psychoanalytic work. (I also believe the opposite – that individual psychoanalytic therapy is not useful for everyone and other therapies including family therapy may be a better fit.) Misunderstandings may act as a barrier to recognizing the potential

helpfulness of analytic therapy in some cases and, on the basis of this argument, are then unethical.

2 Misunderstandings may prevent family therapists from making use of an analytic personal therapy. I think there is much more to each of us than we can possibly know but regardless of our state of self-knowledge and of our avowed therapeutic model we are involved with families with all aspects of ourselves – even (and sometimes especially) the ones we would prefer to keep hidden. One factor in the renewal of dialogue between family therapy and psychoanalysis is the number of family therapists who first came to understand these ideas through the experience of being patients[1] and found themselves incorporating these ideas into their work.

3 Active misunderstandings waste potentially useful resources which can enrich the thinking of family therapists.[2] Indeed, since psychoanalysis is interested in the-self-in-the-context-of-relationship (rather than the fully interior self of some misconceptions) it is difficult to see how such ideas could not be relevant to family therapists.

Six things

1 Psychoanalytic psychotherapy, like family therapy, is best considered not as a model of therapy but as a heterogeneous culture

I am using the term 'culture' to refer to the ideas and practices of both family therapy and psychoanalytic psychotherapy. The identity of any culture looks clearer from the outside and from a distance than from the inside. (Imagine, for example, trying these days to offer a clear one-sentence definition of family therapy.) As we know, the best way to understand any unfamiliar culture is to avoid the kind of homogenizing talk that gives rise to stereotypes. Descriptions of psychoanalysis that reduce diversity are common in family therapy discourse and often support other active misunderstandings. (It should therefore be noted that my views can only represent a portion of what could be said on these issues from other psychoanalytic perspectives.)

[1] 'Patient' is a difficult term due to possible associations with illness, and passivity. As an ex-psychotherapy patient it does not carry these connotations for me and, in the absence of a substantially better term, I will use it throughout the paper.

[2] And vice versa. Intersubjectivity theory (e.g. Benjamin, 1999) is, in my view, a systemic version of relationships including the analytic relationship. See also Lachmann and Beebe (2002) who locate parent–infant research and adult treatment within an explicitly systemic frame.

The centre of psychoanalysis is the idea of a dynamic relationship between the conscious and unconscious mind, but how these terms are defined and thought about will vary a great deal within the culture. There are variations, for example, between groups of those considering themselves Freudians, Kleinians, Independents, Jungians, Self-Psychologists and Relational Psychoanalysts. But within each of these groups there are also differences. For example, the Independent Group was formed initially as a section of the British Psychoanalytic Society by those who did not want to identify themselves closely with the followers of Melanie Klein or of Anna Freud. But within this group are found those who are eclectic or those with a strong interest in attachment theory, or perhaps those who are strongly influenced by particular figures such as Ronald Fairbairn or Christopher Bollas.

In addition, while the ideas of each of these larger groups were once fairly distinct, the passage of time, the fading of Sigmund Freud's vision of psychoanalysis as a science, a less idealized view of the pioneers of each group, and a greater acceptance of not-knowing are all factors leading to a blurring of the edges and mixing of ideas. The tendency these days of most psychoanalytic training courses – even those not calling themselves eclectic – is for greater pluralism.

As with family therapy there are also national differences in the way cultures of psychoanalysis and psychoanalytic psychotherapy have developed. The work of the post-Freudian Jacques Lacan is most identified with French intellectual modernism and postmodernism but it also has a strong foothold in Australia. Most developments in ego psychology from the work of Anna Freud (1937) have taken place in North America. These tend to give less emphasis to the role of both external relationships and internal relationships (in the way that object relations theory has developed in the UK). Ego psychology, in turn, has been the context for the counter-development of strong relational models in the US – self-psychology and intersubjectivity theory. These, so far, have not been much taken up by UK psychoanalytic psychotherapy which has its own relational model (object relations theory) and a growing interest in attachment theory.

2 Authoritarianism is not – and cannot ever be – a psychoanalytic position (or any kind of therapeutic position)

Concerns about authoritarianism in psychoanalysis are closely linked to the second order movement in family therapy and more recently to the ideas in the narrative and social constructionist therapies of what

might constitute modernism (as opposed to postmodernism). In these discussions, psychoanalysis is seen as one of the chief examples of modernism.

In this active misunderstanding at its most stereotyped, the analytic psychotherapist is an expert on the human mind. She knows first and best the truth about the patient. This is because the analyst believes she knows how to read the Rosetta Stone of the patient's unconscious and gradually these hidden truths are conveyed to the patient in a series of interpretations. A more postmodern view of this might say that the therapist and her psychoanalytic culture come to colonize the patient. (This is close to the Gergen and Kaye (1992) quote above.) This way of positioning psychoanalysis as other took over from the belief in psychoanalysis as linear (rather than circular) which was prevalent during 'first order family therapy'.[3] And what could underline this power difference more than having the patient lay down on a couch and the therapist outside the line of the patient's vision sitting up?

I remember being so convinced by this view of analytic psychotherapy prevalent in late 1980s family therapy that I was rather surprised by my therapist listening very carefully, wishing to understand what I thought and felt. Interpretations tended to be offered by her quite tentatively and seemed generally to invite further thinking or dialogue rather than to present some final truth. I began to wonder if she might be a bit of a maverick. In fact, I was a little disappointed that more was not done for me.

Analytic psychotherapy, if it is to be of any use, depends on forming an alliance (or what family therapists might think of as working collaboratively) with the thinking capacity of the patient (Box *et al*., 1994). Even in regression (a powerful re-experiencing of early states of mind in which the therapist frequently represents some aspect of the patient's internal world of relationships) there is usually an observing and thinking part of the patient alongside that of the therapist.

It is, of course, possible to tell patients what to think; it is not uncommon for patients to want to be told what to think, but it can never be therapeutic. There are, frankly, times when the idea of being

[3] I have placed this term in quotation marks since I do not believe it makes good sense. It seems commonly used to denigrate a variety of older models of family therapy (Pocock, 1999). If a second order position is the reflexive use of theory or practice then the term 'first order' might be better reserved for *any* moment in *any* therapeutic practice when reflexivity slips and the therapist becomes convinced that her way of seeing is the only way. None of us, I believe, are entirely immune from first order moments.

able to change people instrumentally (as second order family therapy calls it) by telling them what to think and do is very appealing. If only change was that easy! The same psychological issues may come up scores of times and be talked about in many different ways but the moment of change is not one in the power of the therapist. It is not even a direct product of collaboration – although there can be deep mutual satisfaction when something has been worked out together over a long period of time. In the end the patient can only arrive at a particular emotional truth on his own.

I would argue that analytic psychotherapy is possibly the least didactic therapy. The learning – or probably it is better to say unlearning and new learning – depends not on the therapist's power but on the patient's experience in the analytic relationship. I think a very good description of this experiential psychic change is found in Bateson's (1979) ideas on binocular vision and news of a difference. For example, a woman patient of mine, scapegoated as a child and tyrannized by her father, is so convinced that I will shout at her if she is ever late for a session that she makes elaborate arrangements for this never to happen despite having to travel by bus. Inevitably, one day the bus is delayed and she is late and sits (feeling very hot) silently waiting for me to begin raging at her. This is explored a little and after a while she explains that she knows it is true that I am not furious with her. She knows this from the tone of my voice. At the same time, she says, it still *feels true* that she expects me to rage at her. Both things now seem possible, whereas before an angry internal part of her was firmly, in fantasy, located in me. Some certainty has been dislodged in her by this new experience.

I think there is a widespread fear of authoritarianism in contemporary family therapy culture which seems not only to have distorted the perception of psychoanalysis, but also to have underpinned the first order/second order split. At times this seems to extend into a reluctance to hold any specialist knowledge. All this, I think, is based on a partial reading of postmodernism. Basically the postmodern critique says that reality or truth cannot be captured or fully represented in language. There may be many descriptions that can give an account since reality gives quite a degree of wriggle-room. Some family therapists have begun to worry that, if this is the case, their knowledge can overpower the self-constructing power of those who are seeking help. There is instead great hope placed in re-storying, co-construction and building new narratives. But this, in effect, reduces all experience to language and is not what postmodernism

says. It also, as Carmel Flaskas (2002) notes, offers a very fluid notion of the self that is at odds with everyday experiences of what it means to be a person in which a sense of identity (even a denigrating one) is held on to tightly for fear of disintegration.

Another important point about postmodernism is, I think, the one made by Steven Frosh (2002). Postmodernism shows the limitations of language in capturing reality – that there is a point in therapy in which available words dry up. We are left then with our other pre-linguistic human capacities of experiencing the other or – as Alice Miller (1987) puts it – witnessing. This is not to say that new ways of representing (or symbolizing) some of this experience cannot be found but we are more frequently at the edge of our capacity for words than the constructionist-narrative turn in therapy recognizes.

My other concern, linked to this, is that too much hope in the capacity for re-storying leaves too small a role for the task of bearing painful feelings in family therapy. One can simply construct a less painful story. But I am hopeful that narrative therapy, at least as it has been taken up in the UK, is quite strongly influenced by John Byng-Hall's (1995) interest (from attachment theory research) in emotionally coherent stories. These are narratives that incorporate a living history of emotional experience. I was also heartened to read Lynn Hoffman's (2002) absorbing 'Intimate History' of family therapy which, despite steering well clear of anything psychoanalytic in family therapy, ends with a great respect for the possibilities of unconscious emotional communication (although using different words).

3 Psychoanalytic psychotherapy is not taught primarily through its theory which, accordingly, does not try very hard to be reader-friendly

The culture of family therapy is, I think, distinct from that of psychoanalysis in one way, which is in its use of technical terms. Family therapy with its ethos of radicalism seems constantly to be re-inventing itself, with a tendency to split off from its past every few years. Each new movement carries new terms, and one characteristic of those family therapists who have been around for some time is that they begin to grumble that the new jargon simply recycles old ideas. I will not say too much about the merits of this argument but will simply use it as a point of contrast with the opposite tendency in psychoanalytic terminology.

Terms in psychoanalysis tend to be overly conserved (Susie Orbach, personal communication) so that the same term can be stretched over

the years to mean several different things. A good example is that of 'countertransference' which – in Freud's (1910) original view – was simply the unconscious reaction of the therapist to the patient and was seen as a complicating factor in understanding the patient and, therefore, rather a nuisance. Later countertransference became seen as potential information not solely about the therapist, but also about the patient via projective identification (Heinemann, 1950). In relational psychoanalysis (Mitchell and Aron, 1999) the same term is used differently again. Here the therapist is not seen as *reacting* to the patient's unconscious but each are seen as interacting at both conscious and unconscious levels – in other words as a system. Thus transference and countertransference might here be defined as all that which is in the mind of patient and therapist respectively but in the context of the relationship with each other. Some writers, such as the intersubjective theorist Donna Orange (1995), have suggested a new term – co-transference – for this.

Many of the most useful terms in psychoanalysis do not intuitively yield up their meanings. Some exceptions are Donald Winnicott's (1965) idea of 'emotional holding' and Wilfred Bion's (1962) 'reverie' but terms such as Melanie Klein's (1946, 1952) 'paranoid schizoid position' and 'depressive position' – in many ways crucial to understanding much contemporary psychoanalytic thinking – seem almost perversely non-intuitive. (I will return to these terms later.)

Primary to clinical training is the training analysis or training therapy typically three to five times per week for a minimum of five years. The experience of being a patient is central to the training and theoretical teaching supports this. Reading about projective identification can be hard-going and baffling. In contrast, discovering as a patient that what one is attributing to the therapist or others is actually something of oneself can be shocking but also compelling and unforgettable.

All told this makes acquiring knowledge of psychoanalytic ideas very difficult through reading alone. I say this not to put anyone off from reading but to help explain why terminology is often opaque and hard-going.

4 Psychopathology and blame are not the same

The terms 'pathologizing', 'parent blaming' and, especially, 'mother blaming' have become, I believe, crucial and powerful boundary markers in some parts of contemporary family therapy discourse

and function in the same way as 'linear', 'first order', 'modern', 'expert'. In a recent conversation with a very experienced family therapist he talked about transgenerational issues in families and then, as an automatic aside, apologized that he might sound rather blaming. Terms like 'mother blaming' which I call badges of shame (Pocock, 1999) only operate in a disciplinary manner if they remained unexamined. I would like to reconsider the assumption that the notion of psychopathology is *just blaming* through an analogy.

A woman breaks her right leg and is taken to casualty complaining of considerable pain. The doctor, mindful of the dangers of pathologizing, decides not to draw attention to the damaged leg at all but to concentrate on strengths, and says, 'But you have such a good left leg. Have you considered hopping?'

Of course, in this example, the patient would hopefully soon redirect the doctor back to the damaged leg. The doctor's knowledge about pathology is in tune with the patient's view of the matter. The knowledge of pathology is not therefore experienced as a problem. In fact, one would say that the doctor would not be able to discharge his duty of care without a detailed knowledge of how the body can suffer and a willingness to attend to this suffering. A concentration on the strength of the undamaged leg would probably have been experienced as neglectful and dismissive. (I should stress that no criticism of valuable strengths-based therapeutic work is meant here. It is the possibility that the avoidance of psychic woundedness may feel neglectful by the patient that I wish to highlight.)

A more complex problem is presented in analytic psychotherapy. Here attempts by the patient to feel better may lead to unbearable aspects of the self being projected outside and on to others. The therapist's knowledge of these processes (hopefully, carried within a frame of uncertainty) is not going to be received immediately as helpful and may well be experienced as persecutory and blaming.

There is no doubt that psychoanalysis contains some potentially good put-downs which have found their way into popular culture such as 'neurotic', 'psychotic', 'narcissistic'. But within psychoanalytic psychotherapy these are theoretical technical terms referring to states of mind (which should, in any event, have no place in any therapeutic encounter). They are no more inherently pejorative than, say, technical terms in medicine or any other occupation including family therapy. However, this is not to say that therapists cannot use these terms pejoratively. Hate can get into almost anything (even positive

connotation) and should be recognized as such. So what I am saying is that psychoanalytic psychotherapy is at times inherently painful but not inherently blaming.

Blame of others and blame of self are, though, regular aspects of the human condition (corresponding to what Klein (1952) calls the paranoid schizoid state of mind which we have all experienced and can all experience again in times of duress). The progress of psychoanalytic therapy is a movement *from* blame through tolerance and understanding of painful states of mind to greater acceptance of self and others.

I believe the attempt to avoid parent blaming has led some parts of family therapy culture to almost give up on any theories of family processes. Lynn Hoffman's recent book (2002) outlines her journey to an almost completely non-theoretical position. What is left is intuitive, poetic and warmly supportive. Knowing seems to be removed through fear that it will be used in an authoritarian and fault-finding manner. But don't families wish us to know some things they don't know? (What I should add perhaps is that a therapist with Hoffman's extensive experience can never be short of knowing. Intuition is not a personality trait but based on layer upon layer of experience built up over many years.) My own view is that knowing and not-knowing need to be held responsibly in a careful balance and I would identify with Glen Larner's (2000) thoughts on this.

I think this disabling fear of blame in families does not come primarily from our theories but from elsewhere – a conviction in many parents and children that they are bad and blameworthy, and a fear that inevitably the therapist will come to see this and their terrible secret will be out. Parent blaming *is* real and damaging but exists not, I think, primarily in our theories but in the continuous and secret conscious or unconscious attacks that parents make on themselves and then, understandably, try to get rid of. Of course, these self-attacks can be assisted by popular knowledge of processes of attachment and the developmental importance of maternal and paternal care in general but twisted to be used against the self. But is, for example, a postnatally depressed mother blameworthy when her child develops a primary insecure attachment? She might be convinced this is the case but I do not know of any psychoanalytic or family therapy theory that would agree. Instead, in such a case, our theories should assist in a search for a compassionate understanding of the complex internal and external relational processes that underpin and support the depression.

In short, acknowledging, understanding and challenging painful self-blame seems to me to be far more helpful than trying to rid family therapy of its theoretical base or projecting its fears of pathologizing into psychoanalysis.

5 Psychoanalytic psychotherapy is not primarily about working with history

The idea that analytic psychotherapy is preoccupied by history used to be a boundary marking misunderstanding during the time when structural and strategic family therapy models were prominent, since these took no interest in historical issues. I include it now because of its significance in understanding some important theories of change in analytic psychotherapy.

Although there may be some enquiry into history during a brief assessment stage, psychoanalytic work commonly relies on experiential changes in the context of the here-and-now relationship with the therapist. However, one sign of a good enough therapy is the development in the patient of an emotionally coherent narrative history. But this is generally a good side effect of change rather than the main focus of the work.

Many people who suffer as adults seem to have little or no sense of personal history. Often there is an idealized view of childhood ('It was perfect') or a dismissive view ('It was just like everyone else's'), or there is little that has been processed into autobiographical memory ('I can hardly remember anything before I was 9'). Children with the least attuned parents tend, when they grow up, to become parents themselves with a limited or dismissive emotional history. This dismissive style in parents is, from attachment research, strongly associated with insecure attachments in their children – especially insecure avoidant attachments (Main *et al*., 1985).

A sense of history results from a process of reflection in oneself or with others. Many patients have had very little opportunity for this as children or as adults. Even persons apparently preoccupied with aspects of their history often have important elements missing as, for example, in melancholic grief reactions in which the lost person is idealized and hated aspects of the same person are turned unconsciously against the self.

For Christopher Bollas (1987), for example, the unconscious is the place for memories of the earliest experiences of care, but the term 'memory' is being used differently to the usual vernacular meaning. It is not something recalled from the past but current and alive. I think

the crucial idea here is Freud's view that the unconscious is timeless. Regression in the transference allows these timeless memories to be accessible for thought. In the weeks leading up to a summer break a patient may re-experience vividly the rage and upset of childhood abandonment. The memory of the abandonment is relived and the therapist is experienced as the longed-for but hated object or other. However, alongside memory – now made conscious – is reverie – the capacity of the therapist and thinking parts of the patient to bear, accept and make sense of the feelings, perhaps for the first time. Through these here-and-now experiences, timeless unconscious memory (in which the patient always has, always is and always will be abandoned) begins to turn into a capacity for a bearable personal emotionally coherent narrative. The patient may then be able to say, 'I know where this feeling comes from – it's history'. It no longer needs to be associated so strongly with events or relationships in the present.

6 'Separation' in psychoanalytic psychotherapy is a technical term used to signify the start of a new capacity for relating rather than to signify the withdrawal from relating or the end of a relationship

The postmodern philosopher Jean-François Lyotard (1988) writes about disputes – he calls these differends – that can never be resolved since the protagonists are, without realizing it, using the same words to mean different things. The term 'separation' is, I believe, the cause of a differend between family therapy and psychoanalytic psychotherapy.

In this active misunderstanding in some parts of family therapy, the goals of separation and individuation in psychoanalytic psychotherapy are seen as equated with Western (or more specifically North American male) values of rugged individualism. At its most stereotyped the image that comes to mind is the production of John Wayne and Clint Eastwood characters – separate, independent, needing no one. Attached to this misunderstanding is therefore an accusation of cultural insensitivity. Evidence from Asian cultures (in which issues of personal autonomy are said to be managed very differently) is often used to show that separation is a Western cultural preoccupation. (What I would say is that becoming an individual is a universal issue but mediated differently through cultural variation.)

Once again, I think the non-intuitive nature of technical terms in psychoanalysis has played an unhelpful role. Who, without prior knowledge, would guess that the Kleinian term 'depressive position'

(Klein, 1935) refers to the capacity to relate to the other as a separate person in a respectful manner in which there can be a meeting of needs not based on manipulation or a distorted view of their otherness? The achievement of separation in analytic psychotherapy is not to go it alone but to be capable of participating in relationships based on mutual care and respect. Western cultural individualism of the lonesome cowboy type would be seen, not as a model of psychological health but, more likely, as an example of destructive narcissism in which the individual denies and turns against his own need of others and instead uses other people in a ruthless manner.

A key idea in psychoanalysis is that projective identification is a defence against separation. In analytic psychotherapy the therapist from the patient's perspective quickly comes to be experienced as a remarkably familiar figure. This is the result of transference. The therapist is not perceived as a separate person but, in unconscious phantasy, as aspects of internal relationships based more or less on the experience of earliest important parental relationships. This very helpful process is of course facilitated by the therapist taking some care not to reveal too much of herself to the patient. (However, the cold, unresponsive, blank-screen analyst is, I believe, mostly a myth.) These internal relationships are then re-created between the patient and therapist but can then be talked about.

The therapist can feel a powerful – although often subtle – pressure to become like the projected aspect – perhaps an ideal mother who will see this patient as special above all others. But the patient is effectively relating not to the therapist but to part of his self. Excessive projective identification outside the therapy room is therefore seen as a barrier to understanding and respecting the needs of the other as a person in his own right.

Projective identification thus involves the use of the other. In this theory, a partner or a child can be the repository for disowned aspects of the self and this can form a very stable interpersonal defence affecting the life chances of both the person projecting and the person projected on to. The other is used – not experienced as a separate being with an equivalent centre of self. The task of psychotherapy is to help the patient to understand that what he perceives is part of himself. This is referred to by the terms 'withdrawal of projection' and 'integration'. The therapist begins to be experienced more realistically and it is often a warm period in the work where genuine concern and love for the other can flourish. It is also usually a time of substantial systemic shifts in the other significant relationships of the patient. This

process is often called experiencing the other as a whole object – the depressive position – in Kleinian terminology.

Winnicott (1965) calls this the stage of concern and I also find the terminology of Jessica Benjamin (1999) – an American analyst and feminist – very useful. She describes this process as moving from object relatedness to subject relatedness. The other can now be seen as a subject in his or her own right. This point of separateness is thus the beginning of a non-exploitative kind of relating.

Summary

This concludes my six things worth understanding. I have covered issues of diversity, authoritarianism, terminology, blame, the place of history, and the question of separation. Now, in summary, let me reduce all of these points down to one. Psychoanalysis has, for twenty-five years or more, too often been a denigrated object for mainstream family therapy. There are many signs that family therapy no longer needs to do this. I am hopeful that each therapy culture can increasingly see the other as interesting, diverse and neither ideal nor bad. In other words, I hope that there is now sufficient separation to have a relationship.

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