**"Found At Sea: Depth Psychotherapy for Unfathomed Times"**

Presented by:

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**HANDOUT OF KEY CONCEPTS & TERMS FROM PSYCHOANALYSIS**

***Supplemental to Molly’s presentation on 4/1/2022***

**I. Quotes from today’s conversation:**

“Our practices as clinicians are informed by the environments in which we and our patients are forced to contend.”

“In depth psychotherapy and psychoanalysis, we help people contact their minds by accompanying them with curiosity, and we support our patients in breathing some air into spaces that have been collapsed by social and familial messaging that leaves us feeling helpless and fragmented.”

“I honor my patients’ suffering because we live in a social world that bids us to dissociate from our loneliness and grief, and therefore, we don’t really get a chance to know our loneliness and grief, and understand its companionship and useful messages about love.”

“Psychoanalysis is constantly evolving and changing its shape, and it is not a monolith.”

“People’s individual choices are limited in part by what they can imagine. We don’t know what we don’t know. We also don’t let ourselves know what we know.”

“If we come to understand that people’s choices, and their lives, are limited in part by what they can and can’t imagine, it is also important to claim that what people can imagine is shaped in part by social interpellations, racialized subjectivities, resource entitlement, assumptions and expectations of what is possible, learned value systems and ways of thinking, and the desire to either be seen as good or to preserve their environments as good. These are all interdisciplinary, intersubjective psychoanalytic approaches to understanding something about why people might do what they do, and what personal and social change might really mean.”

“In order to dream up new actions and new possibilities, towards a liberatory future, beyond the paradigm we can imagine, we must grapple with these known, but unthought and unformulated and maybe even disallowed, fragmented deeply-lodged beliefs and untangle them from our assumptions of truth.”

“Curiosity and spaciousness can support a process that can unhook us from the limiting and at times problematic ways we have tried to cure ourselves through our symptoms.”

“If we are willing to be surprised by our bodies, by our countertransference, by emergent and unformulated experience and affect, what might we have to let go of, and what might we need to acknowledge?”

“Our position as psychoanalytic practitioners, is a position of humility, of a continual titration of what we know and what we cannot yet know, and of an increased reliance on wondering, formulating with, being with what’s emergent.”

**II. A few pieces and parts from others’ minds to describe psychoanalysis and its use**

**A. What is** **“The Psychoanalytic Sensibility”?**

Thomas Ogden (2005), in “What I Would Not Part With”, lists several key tenets of analytic practice that he would “not part with”:

1. Being Humane
2. Facing the Music
3. Being Accountable
4. Dreaming Oneself into Being
5. Thinking Out Loud
6. Not Knowing

**B. What Defines a Psychoanalytic Therapy?**

Nancy McWilliams (2004). From “Psychoanalytic Psychotherapy: A Practitioner’s Guide”

Freud invited people to recline on the couch, facing away from him. This allowed for a dropping of social niceties and invited a free-flow of ideas which he believed held information about the unconscious in the form of slips, associations, dreams, “reverie,” and more. Slips of the tongue would invite inquiry (“I didn’t mean to say that” “But maybe a part of you did”). Associations are the kinds of thoughts we have when we are talking about one thing, and something else seemingly unrelated pops into our minds. We might not usually say those things out loud because we might be concerned it’s unrelated or changing the subject, or even uncool or may bring up shame, but Freud would likely have seen those associations as meaningful. Dreams and reverie are equally important: Freud has said, “dreams are the royal road to the unconscious,” and analyzed many of his own and his patients dreams. Reverie is our waking dream life, which, similarly to free association, may be interpreted as the kinds of fantasies and thoughts we may not allow ourselves to have, consciously.

“Freud understood his patients' symptoms to be expressing conflicts between unconscious wishes, ( e.g., for sexual or aggressive self-expression) and an equally unconscious intolerance of those wishes—intolerance that represents the internalization of societal messages, conveyed by caregivers, to the effect that certain desires are inherently unseemly or dangerous. Paralysis of the hand, for example, a disorder that is inexplicable neurologically yet was common in Freud’s era; was interpreted as a neurotic solution, to the conflict between the wish to masturbate and the horror of masturbating, both of which were outside awareness. By helping via free association to make such tensions conscious, Freud tried to foster a sense of agency (in this instance about managing sexual needs), in place of the paralysis that was handling the problem outside of consciousness. In other words, he was trying to substitute a mindful, reality-oriented process for an automatic, unformulated, somewhat magical one that operated at the price of symptom formation.” P. 16

Freud developed the technique of free association from a failed analysis. It can be helpful to remember that he was learning as he went, and modifying his theory and technique as he gained experience.

**C. Tummala-Narra’s (2016) Framework for a culturally responsive psychoanalysis:**

From “Psychoanalytic Theory and Cultural Competence in Psychotherapy”

“I outline a culturally informed psychoanalytic framework that considers several key areas that build on existing contributions, particularly those from relational theorists, and that expand existing conceptualizations of cultural competence. These areas of emphasis and related therapeutic strategies reflect a call for active engagement of psychoanalytic theory with cultural competence and the application of psychoanalytic contributions to culturally competent therapeutic practice. The framework includes the following areas of emphases and strategies:

1. recognize clients' and therapists' indigenous cultural narrative and the conscious and unconscious meanings and motivations accompanying these narratives;

2. recognize the role of context in the use of language and the

expression of affect in psychotherapy;

3. attend to how client's experiences of social oppression and stereotyping

influence the therapist, the client, the therapeutic process, and the outcome;

4. recognize that culture itself is dynamic and that individuals

negotiate complex, intersecting cultural identifications in creative, adaptive ways and in self-damaging ways, as evidenced in the use of defense; and

5. expand self-examination to include the exploration of the effects

of historical trauma and neglect of sociocultural issues in psychoanalysis on current and future psychoanalytic theory and practice.” (p.78)

**D. Quote from McWilliams (2004):**

“Clinical psychoanalysis, although invented as a therapy, has come to be defined as an open-ended effort to understand all,of one's central unconscious thoughts, wishes, fears, conflicts, defenses, and identifications. People may seek analysis in order to pursue an agenda of personal growth or to develop a depth of understanding about universal issues with which their own patients struggle. Psychotherapy has more modest goals, such as relieving specific disorders, reducing suffering, and building stronger psychic structure. Analysis continues to be the most effective treatment known for resolving problems embedded tenaciously

in one's personality, whereas therapy may adequately ameliorate more focal difficulties. Despite the convention of defining analysis as a treatment involving three or more sessions a week (usually on the couch), and psychodynamic therapy as twice a week or less (usually

face to face), most psychoanalysts would probably agree that **the critical difference between an "analysis" and a "therapy" is what happens in the therapeutic process, not the conditions by which the process is facilitated. To accomplish the ambitious task of a full analysis, clinical experience suggests that patients must become comfortable enough to allow themselves, when in the therapy office, to “regress**" — that is, to feel the intense emotions characteristic of early childhood.” p. 17

**E. Quote from Tummala-Narra (2016)**

“At its core, psychoanalytic therapy has been described as "inherently subversive" because it sets out to "tell the truth about sexuality, aggression, dependency, narcissism" (McWilliams, 2005, p. 139). McWilliams further included the therapist's self knowledge, particularly of

the therapist's unconscious life, through one's own therapy, and the development of a comfortable working alliance as essential components of psychoanalytic therapy. Additional techniques in psychoanalytic therapy include the therapist's engagement in listening to the client in an active, empathic, and respectful manner, the encouragement of free expression ( e.g., free association), search for meaning of the client's experience, attention to what

is not talked about and what is not named or owned in the client's experience, attention to resistance and reducing the client's shame concerning the challenges involved with therapeutic change, and the ability to address transference and countertransference (Mc Williams, 2004, 2014). Among other conceptualizations of the aims of psychoanalytic therapy, scholars have emphasized the importance of self-realization, the "containment and transcendence of opposing tension states" (Summers, 2000, p. 551), and authorship over one's own life (Benjamin, 1988). As such, psychoanalytic approaches tend to conceptualize diagnosis more so in terms of personality organization (psychotic, borderline, neurotic), defenses, relational patterns,

and subjective experiences, rather than Diagnostic and Statistical Manual of Mental Disorders (DSM) categorization (Mc Williams, 2012; PDM Task Force, 2006) and the therapeutic process as involving the therapist's attention to his/her own unconscious processes in addition to those of the client.” p. 71-72

**III. Some Key Psychoanalytic Terms (as found in McWilliams, 2004)**

**Abreaction** A somatic experience of energy discharged into language. “Ab” means “away from,” in this case, the person wants to get away from the feeling. It is an experience of wanting to “get something out” by speaking. This is what psychoanalysis and the “talking cure” relies upon.

**Abstinence** A therapist should not interfere with a patient’s life. You might think of it as, it’s not your life, it’s theirs, and their choices to make— the patient has to live with and bear the outcomes, not you.

**Cathexis** a Strachey translation of “investment,” cathexis describes the experience of adhering or attaching one’s energies (thoughts, affects, drives) onto another person, object, memory, identity, or worldview. A person cathects, or invests, their psychic or emotional energy into a place, person, thing, identity, etc.

**Countertransference** The feelings, thoughts, experiences, etc of the patient on the part of the analyst. Freud saw countertransference as interference with the transferential and analytic process, whereas later analysts came to make use of countertransference as information about the transference, projections, projective identifications, and other communications from the patient’s unconscious.

**Defenses** In German “abwehr”- not so hostile as our translation of “defense”. Defenses here is more like, “protection” or “shoring up”. In fact much of his writing, in German, is colloquial and easy to follow. The English translations become medicalized, cold, challenging to understand. He is writing to the general public, in a very simple way. As McWilliams writes, “It has been a loss, for example, to have Freud's “it," "I," and "I above" represented by the Latin terms "id," "ego," and “superego.”" (regarding what’s lost in translation) p. 16

**Displacement** Displacing an affect or emotion onto something less “loaded,” such as displacing one’s anger or aggression towards a partner onto the family pet, or displacing one’s anger and hatred for their mother who is sick or otherwise fragile onto themselves.

**Evenly-hovering attention** Listening to patients on multiple registers without focusing in too sharply on any one thing.

**Neutrality** Therapist neutrality is aimed at offering a space for the person’s projections to come to fruition. The aim is to help the resistance lower/lessen enough in intensity that we can help someone get in contact with the unconscious material and defenses they have presumably come in for help with.

**Projection** Our imagination of someone/who someone is/what they think or feel or who they are based on what we already know or have come to expect about ourselves and/or others. **Projective Identification** When a feeling or belief about oneself is so intolerable it must be evacuated into the therapist (or other person) such that the therapist can identify with the feeling/experience/identification *as though it is her own.*

**Repression** The unconscious act of disallowing an experience, thought, desire, or affect to come into consciousness or be thought about.

**Resistance** The affective, psychic, and verbal barriers that patients put up to protect their familiar and safe, though often primarily unconscious, organization of the external and internal world. There is also literature describing how resistance is often quite protective, and supportive of a person’s resilience.

**Therapeutic alliance** The work that the patient and analyst do together; the creative, generative, collaborative work towards addressing the pain and problems, supporting the growth of resiliences and agency on the part of the patient, and bringing to conscious mind and agentic action the patterns and unconscious enactments that have been perpetuating painful repetitions of unresolved historical trauma/traumata. The aim is for this to be internalized by the patient and a healthy therapeutic alliance, perhaps even more so than symptom reduction, may be considered an indication of a “cure”.

**Transference** The act of transferring past relationships onto present/current relationships.

**Unconscious** Ogden (2005): “The unconscious is an immanence, not an oracle.” The unconscious is a space into which affect, experience, desire, and pain is repressed. Repression happens for a variety of reasons, including experiences that are too much or because we do not know what to make of it/how to process or find meaning. Individuals and groups alike are considered to hold an unconscious, which effects processes, relationships, and much more.

**IV. Freud’s evolution of models of the mind**

**Economic model** Energy and **cathexis**. Energy is expended but never erased; this model is a foundational aspect to the drive model and the defenses, including **repression** and **repetition compulsion,** as well as **sublimation**: What is felt is never fully gone away, it is repressed, repeated, sublimated, displaced, etc.

**Topographic model** Unconscious, Preconscious, Conscious. More linear, evolutionary. (Freud was a Darwinian.)

**Structural model** Id, Ego, Superego. More about states/relationships and developmental, yet not linear. Id is originally “It,” Ego is originally “I,” Superego is originally “I above.” Id: Emotion/physicality; Ego: Self; Superego: Evaluative capacity/Judgment.

**V. Key Concepts of Psychoanalysis**

from J. Shedler (2010) “The Efficacy of Psychodynamic Psychotherapy”

<https://www.apa.org/pubs/journals/releases/amp-65-2-98.pdf>

*(Compilation borrowed from Jesse Metzger, PsyD)*

* Unconscious mental life
* The mind in conflict
* The past lives on in the present
* Transference
* Defense
* Psychological causation

1. Unconscious mental life
   * The *unconscious* : “thoughts, feelings, and behaviors that we disavow, repudiate, or defend against” (p. 34)
   * “It is not just that we do not fully know our own minds, but there are things we seem not to *want* to know” (p. 12)
     + “[Jill’s view of her sister/father] once served a purpose… it may have allowed her, as a small child, to preserve a desperately-needed sense of safety in an environment that was terrifyingly unsafe” (p. 14)
   * “Most psychological difficulties were once adaptive solutions to life challenges… Difficulties arise when circumstances change and old solutions no longer work, or become self-defeating, but we continue to apply them anyway” (pp. 14-15)
2. The mind in conflict
   * “We can have loving feelings and hateful feelings toward the same person, we can desire something and also fear it, and we can desire things that are mutually contradictory” (p. 15)
   * Conflict : contradiction or dissonance within our own minds
   * Common areas of conflict:
     + Intimacy (e.g., romantic attachments to unavailable partners may represent unconscious compromise between desire for closeness and fear of dependency)
     + Anger (e.g., one is unable to acknowledge or express anger toward others but instead treats him/herself in self-destructive ways)
   * Recognition that inner dissonance is part of the human condition
     + e.g., Love and gratitude can coexist with anger and resentment
   * Support for this notion: “Far from discrediting core psychoanalytic assumptions, research in cognitive science and neuroscience has provided an empirical foundation for many of these assumptions” (p. 19)
3. The past lives on in the present
   * “We view the present through the lens of past experience, and therefore tend to repeat and recreate aspects of the past” (p. 20)
   * It is impossible *not* to perceive and interpret the present through the lens of the past
   * Examples (pp. 20-21)
     + Child receives undivided attention from mom only when physically ill, carries this into future relationships
     + Victim of childhood physical and sexual abuse recreates role patterns of abusers, victims, rescuers with others in life, including the therapist
4. Transference
   * “The activation of preexisting expectations, templates, scripts, fears, and desires in the context of the therapy relationship, with the patient viewing the therapist through the lenses of early important relationships” (p. 23)
   * Different patients see the therapist in vastly different ways
   * These perceptions may diverge wildly from our self-perceptions or those of people who know us
   * Central premise of psychoanalytic psychotherapy: “problematic relationship patterns reemerge in the relationship with the therapist” (pp. 24-25)
   * Distinction between PP and other forms of therapy (e.g., CBT):
     + Transference not ‘incidental,’ nor a ‘distraction’ from the work, it is at the heart of therapy: “It is specifically because old templates become active and ‘alive’ in therapy that we are able to help patients examine, understand, and rework them” (p. 23)
   * The most effective therapists are those who recognize transference and utilize it therapeutically
   * Only when therapists delivering manualized CBT *departed* from the manual (by focusing on transference) were they rated as most successful
   * Transference in the therapy relationship vs. in other relationships
     + Stirs up powerful longings, dependency
     + Regressive pull
     + Asymmetrical relationship, absence of information about therapist, filling in ‘gaps,’ as like with Rorschach
5. Defense
   * “Anything a person does that serves to distract his or her attention from something unsettling or dissonant can be said to serve a defensive function” (p. 28)
   * Examples:
     + Being unaware of an undesirable trait in ourselves and being quick to attribute it to others instead (projection)
     + Deciding whether or not one is in love by doing ‘cost-benefit analysis’ (intellectualization)
     + Being oblivious to a spouse’s affair, then become enraged at a friend who’s having one (displacement)
   * Defenses part of our character/personality:
     + “Ways of defending are woven into the fabric of our lives and reflected in our characteristic ways of thinking, feeling, acting, coping, and relating... they become part of our enduring personality or character” (p. 31)
   * “Psychoanalysis helps us recognize the ways in which we disavow aspects of our experience... this has the effect of expanding freedom and choice. Things that previously seemed automatic or obligatory become volitional, and life options expand” (p. 32)
6. Psychological causation
   * Psychic determinism
     + “Nothing in the life of the mind is random” (p. 38)
     + Thoughts, feelings, behaviors, and symptoms are influenced (determined) by the mental events preceding them; they have meaning, serve psychological functions
   * Free association
     + Associative pathways lead to emotionally charged, problematic material
     + World Wide Web analogy: associative networks, content vs. affect
   * Psychic determinism & free association
     + ‘Steve’ example: ‘forgetting’ to take medication
     + Understanding linkages, enabling insight, recognition of irrational fantasy
     + Demonstrates potential futility of ‘patient education’