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A Monopedal Presentation of Interpersonal Psychoanalysis by Edgar A. Levenson, M.D.

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Appearances aren't deceiving, I think, but you have to know where to look.
 -Jane Smiley

Rabbi Hillel - I think it was - was asked to define the meaning of the Talmud whilst standing on one leg (not an easy task as one gets older!). "Treat others as you would have them treat you", he said. Can Interpersonal psychoanalysis be defined while standing on one leg? Some might say that it would require a prosthetic support. Nevertheless, here goes.

Interpersonal psychoanalysis may be defined as the science of omissions. Note omission, not repression. Repression denotes an intra-psychic process, a one-person psychology: something within the person's psyche must be kept down, out of awareness. Omission is an interpersonal event, something is left out in a discourse between people, a two-person psychology.

This is an absolutely crucial distinction between interpersonal psychoanalysis and virtually all other psychoanalytic psychologies, including so-called relational ones (object relations, self psychologies). Although it is true that object-relational and self psychologies are intersubjective, the emphasis is on restitutive function, i.e., making up for deprivations or, at least, supplying a "holding milieu" in which early deprivation may be regressively experienced and then reconstituted by the patient. They attempt to establish an interpersonal milieu within which an intra-psychic experience can take place. The Interpersonal does not do that. It attempts to establish an interpersonal field which may be subjected to direct examination by both participants, and which recapitulates the central problems in the patient's life. This making explicit of what is hidden is the essence of Interpersonalism. It is not a restitutive experience, it does not attempt to supply a better experience than the patient has had, heretofore, in life. Indeed, Interpersonalism expects to fail the patient in the same way as did others in life. We are interested in examining how this failure takes place, even with the allegedly sophisticated therapist. One must admit that,

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in all therapies, the patient ultimately does have a different and better experience with the therapist and that the cure depends on that salutary context. But how we arrive at that goal differs considerably.

To grasp the Interpersonal canon, one must understand that anxiety as an interpersonal event, is the core of the concept. That is, anxiety is viewed as primarily an empathically communicated interpersonal experience (Sullivan, 1953). The infant, child, adolescent - on unto old age, requires other people for the satisfaction of basic needs. To be human is to be related; otherwise one dies. I am talking, not just of emotional satisfactions, but also of basic sustenance. Disruptive anxiety occurs if the individual feels threatened (that is, at risk of deprivation), or experiences anxiety emanating from the necessary Others. Anxiety, then, is an interpersonal event and the person develops a mechanism for avoiding anxiety, what Sullivan called the self-system. This self-system is a conglomeration of defenses, ranging from inattention, avoidance, deep disavowal and, perhaps most important, a series of interpersonal maneuvers to maintain self-equilibrium and to minimize the appearance of situations which threaten to evoke anxiety. Thus, all the security mechanisms of the patient are directed towards the other person to prevent the disintegration of the interpersonal relationship. So, in a word, defenses are against other people, not against one's own unconscious.

All of this exquisitely sensitive interpersonal dynamism is kept out of awareness, inattended. Indeed, to operate, it must be out of awareness. It is therefore axiomatic that the higher the risk - the higher the level of anxiety - the more likely it is that there will be a scotoma, a hole in the fabric of awareness. And the function of the therapist is to locate these absences. It is not where Id was there shall Ego be; but where absence was, there shall presence be.

This detailed inquiry, which is nothing more than asking 'curiouser and curiouser' questions about the patient's reported experience, permeates every area of the therapy. I have, elsewhere, described the "algorithm" of psychoanalysis as consisting of three parts; the first is a meticulously defined frame; second, a detailed inquiry which is a contextual enrichment of the patient's life experience; and third, a meticulous examination of the patient/therapist relationship (loosely called the transference/countertransference). This examination of the relationship emerges seamlessly out of the detailed inquiry, as I shall elaborate later (Levenson, 1982, p.118).

The first step, the frame, consists of the establishment of constraints and limits: those arrangements that are made in psychoanalysis about contractual commitments - time, money, frequency, cancellation of sessions, vacations and so forth. There is, however, a subtler aspect of framing which invokes the detailed inquiry and that has to do with being curious about and asking about the detailed circumstances of how this particular patient got to you and decided to stay with you. Some of the most extraordinary blind-spots seem to overtake analysts at this particular juncture of the therapy.¹ Moreover, it is vital that one explore with the patient what the anticipated cure would consist of. What does the patient want? Expect? Patients often present with a symptom; depression, sexual



difficulties, anxiety, which they presumably want resolved. But the symptom is often a compromise solution, better than something else, something far worse. The patient resists losing the symptom and - oddly enough - will frequently quit therapy (by no means happily) if the symptom is lifted by some form of active, interventional therapy. Inexperienced therapists are often perplexed when their brilliantly formulated and incisive early assessments of the patient's problems may lead to a precipitous end to the therapy.

Patients, not unlike the rest of us, resent being understood easily. It makes it look all too simple and the patient feels obtuse. The effect, then, of this first stage of inquiry is to make patients understand that their singularity and privacy are respected; that the therapist is not doling out clichés, not gratuitously "understanding" the patient! Do people wish to be understood? They want empathy, sympathy, respect, appreciation, liking - but understood? I think not. I mean that they don't want to be understood before they understand what is there to be understood. Moreover, the patient has good reasons not to want to know, not to see what is there to be seen; and it is presumptuous in the extreme to rush in to the rescue. Patients certainly must wish to be heard if they say something to you. Even if your inquiry suggests that you do not understand, they will appreciate that you are listening very carefully and not taking for granted what it is you think you are hearing.

All this is prologue to the detailed inquiry into the patient's presentation. The therapist locates these scotomata by looking for absences, omissions in the coherence of the patient's narrative. These 'black holes' are the repository of anxiety and consequently of those issues and experiences which are being excluded from awareness. These absences may reveal themselves by sudden changes of direction, silences, slips, forgettings, postural cues or by indirection. This indirect approach can simply be the consequence of the therapist inquiring into some event in the patient's life without any clear sense of where the inquiry is going, and without any dynamic formulation in mind. There is a vital distinction between a directed inquiry which is Socratic - its intent is to lead the respondent to some inevitable conclusion - and an undirected inquiry which is deconstructive - one never knows quite what will emerge from it. This, by the way, is extremely simple in concept and very difficult to carry out.

The function of a detailed inquiry, then, is not to construct a veridical or instrumentally useful narrative about the patient's life, however helpful and organizing that might be in a psychotherapy sense. It is to deconstruct the story, locate the omissions and investigate them. This does not preclude the investigation of dreams, fantasies or free associations. It is simply that we believe they are swarming around an absence, rather than emerging from a repression. In listening to a patient's account, we are not trying to make sense of it, not doing what Masud Khan disparagingly called, "getting the patient to tell us his/her truth, so that we can tell them the Metatruth," but trying to locate the issues or affects that are inattended, disowned.

Traditionally, psychoanalysis was based on the idea that people acted in predictable ways, playing out predictable patterns. They were driven by universal forces and, therefore, one could speculate about the larger issues:



sexual drives, need for mothering, empathic failure, dependency, fear of separation and loss, or fear of death. It was the age of enlightenment, the age of categorization, and the patient's individual neurosis would be manifest as a member of some such general class of behavior. In other words, we were less interested in the singularity of the patient than in his/her experience as representative of a universal class of behaviors. This is, after all, the entire intent of traditional metapsychologies; i.e., to provide a superordinate blanket of explanation for individual behavior.

We do not seem to believe any longer in clearcut cause and effect and in reliable predictions. In the post-modern world, the failure of explanation, the fallacy of understanding, is painfully evident (Ingram, 1994). People are not totally known to themselves or to others. Perhaps they are not even the same people in different contexts. They may be, as Sullivan contended, the sum of their experience. There may be, within one person, as many personalities as there are experiential contexts.

From all this emerges the third stage of the Interpersonal algorithm, a radical use of transference and counter-transference. Since the patient needs the therapist, he/she will monitor, with great solicitude and wariness, any evidence of the therapist's anxiety and will avoid it! If the patient suspects the therapist is seriously threatened by anger, he/she will assiduously side-step it, all without conscious awareness. That is why what Gill called interpretations of awareness work: that is, when the therapist says, "Perhaps you are angry at me," the patient is receiving permission to feel what he/she already feels. The patient, as Lacan so neatly put it, learns what the analyst knows, which is what the patient has always known. Omissions are not total absences. The patient knows on some level that he/she is not supposed to know what he/she knows. The therapist indicates that anger, at least from the patient, is tolerable. Transference may be defined as the patient constructing the relationship with the therapist in such a way as to minimize anxiety in the interpersonal field and inadvertently and inevitably recreating, in the relationship, the very problems under discussion. Counter-transference, conversely, is defined as what the therapist does not see, does not think to ask about.

Frequently, therapists talk about angry, erotic or bored feelings towards a patient as emblematic of counter-transference. I really do not think so. Those feelings are in awareness and are useful indices of a legitimate experience with the patient. Boredom is a perfectly appropriate reaction to a patient who is involved in a soliloquy, who is talking to himself about himself. True counter-transference is, in my opinion, totally out of awareness. What is kept out of awareness, in this example, is the therapist's anger, which comes out of a desire to be considered or acknowledged. This desire upsets the analyst's view of his/her idealized participation as caring or concerned or generous. To be aware of it, to reveal it, might get him/her into trouble with a supervisor or it might anger the patient who would then quit or denounce the therapist as being "too critical." Patient and therapist collude to not see what is there to be seen. What makes so-called borderline patients so excruciating to work with is that they are exquisitely sensitive to these issues and - unlike the well-behaved neurotic who avoids anxiety - they exacerbate them.



To summarize: Interpersonal psychoanalytic therapy consists of a carefully framed detailed inquiry which mobilizes anxiety by looking where one is not supposed to look. The heightened level of anxiety pervades the patient/therapist field, calling out security operations from both participants and, in essence, recapitulating the material under examination.

Psychoanalytic cure is an enrichment of perception. The patient is left (as is the therapist) with a much more richly textured sense of his/her life; not at all simpler or clearer. I am suspect of those cures wherein the patient learns what is wrong and gets better - as in "my mother didn't really love me." In real life, relationships, particularly with parents, are far more complex than that. Most parents are loving in some ways and not in others. One becomes what one experiences, and to disown the parent is to disown oneself, what one has become. In my training days, it was a truism that one should not be too hasty in joining the patient in his/her parent-bashing since the patient is usually strongly identified with the parent who is being most vociferously criticized at the moment. At a later point, the patient will hesitate to admit to those very qualities after you had both agreed to disapprove of them in the parent.

I think real health is to tolerate ambiguity and paradox in oneself and others - patients, therapists and parents alike. Psychoanalytic change is not, in my opinion, a series of epiphanies and there is not some Holy Grail of mental health which makes it possible to live happily ever after. It is a lifetime struggle to cope with oneself; self-awareness is only the beginning. H. S. Sullivan made a distinction between psychoanalytic treatment and real life. Therapy could provide the patient with insight, a clearer grasp into his/her life. But what the patient then did with that awareness was out of the analyst's purview. Insight did not guarantee change; that requires an additional act of social will.

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See for a sterling example of just such a blind beginning by a very experienced therapist (Levenson, 1982)

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