HOW DOES A PSYCHOANALYST WORK?

DIVING "THE BIG BLUE"

Xavier Diaz: Before we get started, I would like to ask that you respond to my questions openly and freely, as if you were speaking to me from the psychoanalyst's couch.

J.-D. Nasio: How amusing to find myself on the couch after all these years! I am happy to play along, and I am curious to know where this will take us. In any case, working with patients is another way of my being on the couch. Why? A psychoanalyst works with expertise gained from experience and theoretical knowledge, but also with the ability to feel, fantasize, and to listen to his or her unconscious. At heart, being a psychoanalyst is to have never left the couch.

I'm glad you brought that up, as my first question has to do with the couch. Why *do* psychoanalysts ask their patients to lie down? The couch serves a double function for both the patient and the psychoanalyst in turn. It puts the patient at ease, allowing memories, images, sentiments, and sensations to surface more readily. When a patient reclines, his or her view of him or herself in the world changes. The patient trades an external point of view for one that's markedly internal and dream-like. With the patient reclined on the couch, the psychoanalyst is freed from having his facial expressions constantly scrutinized. To always be on guard inhibits the psychoanalyst's ability to experience the sensations and the effects of the patient's word choices on the unconscious. To ask the patient to recline is not just a simple ritual; rather, it is an essential technique that encourages intimacy in speech and facilitates careful listening.

I have a story I would like to share about the couch that I use in my practice, which I designed myself. The furniture maker recommended a small leather sofa that was very pleasing, but I thought the headboard too high. I submitted a draft of a couch with a lower

headrest so that it would be even with my chair. I wanted to keep from having the appearance of being elevated or otherwise separated from the patient. It is a beautiful piece of furniture, without being ostentatious, and is most likely one of a kind. Many a time I thought of changing it, but here it is, thirty years later! On the wall above the couch is a reproduction of a painting by Brueghel. My patients often remark that it is as if the couch is divided. On the left side is the dark and monastic perspective of the Brueghel on an otherwise empty wall. On the other, there is the part of the room that is more light-filled and open.

Is the design of the office really so important?
It is crucial. I attach great value to the aesthetics of the place where I receive patients. You can sense the warmth of the office in its yellow and orange hues that make the space appear lighter and almost transparent. That is what I love about it. Some of my colleagues prefer an austere room that is somber and filled with books. Each psychoanalyst should create a space that works best for him or her and supports the work.

And how do you like to work?
I try to be close to my patients, both literally and figuratively. When the patient is in front of me, I usually sit down at the edge of my seat in order to be even more involved. If he or she is reclined, I slide the chair close to the couch to reinforce the intimacy of listening. Contrary to the caricature of the silent psychoanalyst, being distant and passive, I see the psychoanalyst as a full and active presence, completely focused on the person. As I see it, the practitioner must be a very careful observer, attentive not only to the words and the pauses of the patient, but also to his or her gestures. In fact, good listening begins with good observation. From the moment I welcome the patient in my waiting room, all of my senses, visual, auditory, olfactory, and even tactile, are awake. For example, when I greet with a handshake, I may find the hand to be cold, flaccid, or sweaty. Similarly, I pay particular attention to the packages and objects the patient may bring with him or her. I may smell the alcohol on his or her breath in spite of the mint chewing gum. Whether it is a child sitting at the game table or an adult in front of me, I remain attentive to the expressions of distraction or subtle messages in the

eyes. In short, a psychoanalyst does not only listen with the ears, he or she is receptive to all signs of body language by which thoughts are communicated.

Nevertheless, focusing our senses on the appearance of the patient is not sufficient in itself to allow us to understand and relieve their suffering. It is also necessary for us to experience this suffering, to actually relive it with the patient, but without being overwhelmed by it. It is the only way for the therapist to really understand the pain and know how to treat it effectively. One should not allow oneself to be taken over by a wave of emotion or succumb to one's compassion. That would be an obstacle to understanding the situation. Over the years, the psychoanalyst learns how to master his or her empathy and not allow it to be destabilizing. Certainly, the psychoanalyst remains human and kind, but never compassionately indulgent.

But why not be compassionate?
Because the patient does not ask for pity. The patient asks that we help him or her understand his or her anxiety and help him or her be rid of it. If we give in to compassion, we place ourselves far from the state of attention and lucidity necessary for discovering the root of their problems. We have to choose: either we are compassionate and share the pain as friends do, or while remaining sympathetic we focus our efforts on discovering, behind the patient's symptoms, the real cause of their illness. The cause is most often an emotional trauma from their childhood.

In order to liberate the patient from his or her suffering, it is necessary to understand it, and in order to understand it, it is necessary to experience it without being affected by it. To be precise, it is not the feeling of the actual suffering that brings the patient to therapy, but the older, original pain of their childhood trauma: *analysts must feel within themselves what the patients have forgotten*. Our main challenge as psychoanalysts is to succeed at this mental feat. We must feel the effects in ourselves of their earliest painful emotional experiences, which they have forgotten, while not letting ourselves be affected by it. We must represent the scene with characters who would experience the same emotions, and help the patient re-experience the intensity of that scene, by describing it with words that will carry the most meaning for them. This is a delicate exercise in psychoanalytic perception that leads the therapist to relive in him or herself the patient's

forgotten emotions, and to then transmit them back to him or her. I am convinced that in order to better understand a patient we can only know them within ourselves, at our deepest depths.

Let me be even more concrete. After several months of analysis, at a critical moment in a session, I hear the patient express his or her depression. I try hard to imagine the patient as a child or as an adolescent in a conflict that was important for his or her history. *You should know that every person who suffers harbors a helpless, hurt, child, who seeks in vain to express his or her suffering.* It is precisely this suffering, powerless child, on the verge of finding the right words, who I try to imagine. I feel the effect of not the adult before me, but rather, the effect of the little boy or little girl of the childhood drama that I revive. If, during treatment, the imagined scene is confirmed to be not a simple invention on my part, I try to communicate it to the patient, thereby relieving some of the patient's suffering. Then I would believe that I had cleared up at last one of the major conflicts causing the symptoms.

Lea[1] was a young woman who came to me for a consultation about a serious phobia of streets and public places that kept her cloistered in her apartment. She left her apartment as little as possible, and was always accompanied by a friend or relative in order to come to my office for appointments. After a year of analysis, there were several decisive moments, one of which brought us to the core of her phobia. While she was crying and recounting the acts of a treacherous best friend, I recalled a dramatic scene of her childhood. When she was five years old, her father woke her up to tell her, without affect, of the inexplicable departure of her mother for a distant country. A year later, the patient learned that in reality her mother had died in an automobile accident. Lea had already told me about this horrific event in a tone that was detached and cold, as if she was indifferent. But, it was while listening to her complain of being abandoned by her friend that made me visualize the scene of another abandonment, that of her mother.

Recalling this event, I felt that I could relive the feelings of a little girl struck down by the inept announcement by her father, who was in turn overwhelmed with grief. I had felt with complete lucidity, in the moment of the session, that which Lea would have felt, albeit vaguely or confusedly, those twenty years earlier: a horrible feeling of abandonment and an icy solitude. With infinite tact,

I described the traumatic scene to her and evoked the distress that had devastated her. After my intervention, Lea was overwhelmed, as if she was reliving the confusion of the separation of which she had repressed the pain. In the month that followed the session of reawakening, we had the satisfaction of seeing the majority of her phobic anxiety gradually disappear.

I would like to share something concerning phobia that I see often in patients: when working with a phobic patient, it is always necessary to ask oneself, "Which trauma, which violent separation, which loss (or more precisely), which abandonment—real or imaginary—happened between three and six years of age, on the part of one or the other parent?" In effect, we know that the phobic fear is an anxiety provoked by the early, brutal, unspoken, loss of a loved one. I emphasize that this loss could take place objectively in reality or subjectively "in the mind" of a child. Whether it is real or imaginary, the loss is painful all the same. Having suffered in childhood, the phobic lives in an alert state, in permanent anxiety of a new separation. The person is not conscious of this menace, nor of the worry of a new abandonment. Rather, what *is* feared is a danger from outside, such as the street, the bridge, the plane, etc., and the dangers that, according to the patient, have no relationship to the infantile trauma. Lea, for example, paralyzed by a phobia of open spaces, did not know how the anxiety was provoked by the sudden "departure" of her mother. And yet, from the moment when I brought her to relive that scene of abandonment, which was a result of my own reliving it, her fear of the streets faded. Why? Because all childhood trauma, relived, verbalized, and signified in the current moment of treatment, loses its virulence. When the trauma stays forgotten, it is harmful, but the moment it reenters consciousness it becomes harmless.

The example of Lea shows how I relived in myself, and in turn induced a reliving in the patient, of the emotion of a forgotten abandonment.

Does the psychoanalyst work as much with the heart as with reason?

More so with the heart and, I would say, with the unconscious. When I listen to the patient and I concentrate on reviving the repressed emotion, I engage, quite intentionally, my personal unconscious. The unconscious of the psychoanalyst is the most precious of all tools with

which he works. To act from the unconscious is to allow the subtle vibrations from the unconscious of the patient to reverberate in the unconscious of the analyst. This immersion in oneself, necessary to meet the submerged turmoil of another, has often made me think of the divers in the film by Luc Besson, *Le Grand Bleu* (*The Big Blue*). When I am listening acutely, I have the impression of free-diving into the abyss. I try to flush out from within my own depths the traumatic scenes of the patient in order to then come back to the surface to tell her, at the right moment, with the right words, what I saw. This moment is the decisive intervention of psychoanalytic treatment, one that, it must be emphasized, *does not* happen at every meeting. It is a fascinating psychical act, but it is also one that is indispensable for one to know the origin of the suffering of another and to be able to reveal it to her. I will add that the success of this internal descent depends on a detailed knowledge of the history of the patient, a complete openness, a long clinical training, and above all, a complete personal analysis.

On the subject of psychical diving, I always think of a little-known phrase of Freud's that I believe perfectly defines the way the psychoanalyst makes use of his or her unconscious. Freud wrote, "The psychoanalyst captures the unconscious of the patient with his own." Said another way, when the psychoanalyst submerges into his own depths, he uses his unconscious as a sensory organ, one that perceives the unconscious feelings of the patient. This engagement is the psychoanalyst's greatest commitment to advance his unconscious, as sort of screen, on which the patient can project his or her childhood traumatic scenes. As such, at the most intense moments of listening, when the psychoanalyst uses his unconscious instrumentally, the psychoanalyst is suspended between being master of the situation and exploring his or her own unconscious experience. It is undoubtedly difficult to understand such a split of consciousness and experience. It is something one must experience to understand: to feel perfectly lucid, and at the same time, to be submerged in one's unconscious.

How do you differentiate between psychoanalytic technique as you have just described it and that of psychotherapy?

There is a great difference between the two methods. The listening of a psychologist consists of unraveling a relational conflict while identifying the past and present events that have provoked it. It is

a work of useful clarification that allows the patient to understand the significance of his or her conflicts, and the reason behind their repetition. The listening of the psychoanalyst is very different. It is not only a matter of bringing the patient to understand the relationship between situations that end in conflict, but to incite him or her to relive—as I have just shown you—the emotional upheaval that generates the current suffering. That said, the same practitioner in the course of a cure could use both techniques, in spite of their differences. A psychoanalyst could legitimately begin treatment, as would a psychologist, and then, if the state of the patient demands it, begin to apply the psychoanalytic technique of using the analyst's own unconscious to capture that of the patient.

What are the advantages of one technique over another?
While psychotherapy is a kind of listening that is capable of provisionally removing the symptom, psychoanalysis not only obtains the same beneficial results, but it above all changes the personality of the patient by bringing about a change in his or her attitude toward his or her suffering. When an analysis is effective, it directs the patient to change the very worldview that had made him or her sick. Psychoanalysis teaches him how to go into him or herself and discover the stranger in himself in order to regard him or herself differently and to re-experience his or her illness. "The true birthplace," wrote Marguerite Yourcenar, "is that wherein, for the first time, one intelligently looks upon oneself."[2]

You said, "changes the personality" but doesn't that risk destroying the patient?
I will answer you by citing the words of a patient who recently wrote me after a session. He said to me, "In the work that you do with me, you do not destroy, you do not repair, you do not replace, you do not add, you reinforce the existent." In effect, the principle that guides me is expressed in these terms: the patient, delivered from his or her harmful conflicts, should reconcile with him or herself, find him or herself on the basis of that which he or she is. My goal is not to change the personality, but to enrich it with what he or she already has in him or herself, and if possible, to teach him or her to love him or herself differently. Take for example an artist, who states during the first session that irrespective of the reason that

brought him or her to therapy, he or she fears his or her artistic inspiration would fade during the cure. I would reassure the patient that I will not take away nor add anything to who he or she is and I would affirm that I will try to stimulate in him or her all of their creative potential.

JOËL, OR MY FEAR OF DISCOVERING A CASE OF PSYCHOSIS

How do we define mental health? When do you say that a person is psychologically healthy?
Your question speaks to a number of debates and explorations at the heart of the community of mental health professionals, so I can only offer you a quick response.

In my view, mental health is *the state of a person capable of knowing his or her limits and who loves and accepts them*. To be psychologically healthy signifies that one lives relatively happily with oneself, in spite of the inevitable challenges, surprises, and restrictions that life imposes. Mental equilibrium can be seen as having the will to take action, while having the ability to accept the unexpected and to adapt.

What do you think of madness? Do you believe that recent neuroscientific advances can claim a decisive victory over mental illness?
We are going too quickly! Don't forget that current research in mental health is, sadly, far behind medical research in general. You know that psychiatry and psychology are relatively young sciences. Mathematical study can be traced back to ancient Greece; physics has had already five centuries of existence; chemistry appeared in the eighteenth century; biology is nearly as old; but psychiatry and psychology can be dated at the beginning of the nineteenth century. Recall that madness was not always a synonym of mental illness. It was during the Renaissance that madmen were no longer seen as people possessed by demons and had an illness that deserved treatment, and not exorcism. Medical treatments began to be tested, albeit rather primitive versions. The Renaissance was the era where healers practiced a fraud called "*pierre de tête*." I am thinking of the famous Flemish picture where one can see the work of one of these

charlatans. After having shaved the head of a demented patient and made an incision in the skin on his skull, he then made a show of extracting a bloody stone; a stone that had certainly been stashed in his pocket before the "operation." There is also in the Prado museum a painting by Hieronymus Bosch that is a representation of a similar scene, titled *The Extraction of the Stone of Madness*.

No, we are neither omniscient nor infallible! Our current knowledge of the psyche is still incomplete. Even with the contributions of psychoanalysis and neuroscience, we continue to miss the actual causes of mental illness. We work with hypotheses perfectly formed, we have vastly refined our means of helping patients, and above all we dispense powerful medicine, but, and this is totally unknown to the public, we still do not know how schizophrenia, manic-depressive psychosis or delirium begins and develops. I can tell you without hesitation that we ignore the developmental process of mental illness and, a fortiori, the active mechanism in our medications. We prescribe psychotropic medication that is becoming increasingly capable of mitigating a delirium or of liberating the schizophrenic from an overwhelming hallucination, and nevertheless, we do not know by which neurochemical chain reaction a particular molecule makes a particular symptom disappear. Moreover, do not forget that at the moment that I speak to you there does not exist a psychotropic drug that will heal someone completely. All of our medications have a palliative effect, but never a completely curative one. The medication can suppress the symptom, but it does not suppress the cause of the symptom.

The limit of our knowledge makes us sometimes feel desperately powerless before the intensity of our patients. I saw families trapped for years in a drama because their child had suffered from schizophrenia who oscillated between getting better and getting worse, going back and forth to the hospital. These same parents, who had fought like lions to help at the beginning of the child's symptoms, I later found to be exhausted and destroyed. They revealed a desire to see their child commit suicide so that they could be at last delivered from the madness that threatened them as well.

At the same time, I would like to be clear that outside of these extreme cases, we are beginning to see a reduction in the number of relapses, shorter hospital stays, and an improved rehabilitation program that makes patients more autonomous and better integrated in society, thanks to the work of polyvalent therapies.

As a psychoanalyst, how do you approach mental illness?
Instead of a direct answer, I will tell you about one of my clinical experiences. A long time ago, I saw Joël, who was seventeen years old and accompanied by his parents. As is my habit, I asked that his mother and father stay in the waiting room while I interviewed the son first one-on-one. Joël was a talkative boy, very athletic, who adored tennis. He explained to me that he could no longer go to school because of a paralyzing anxiety. Often, when he would arrive at the entrance to the school, he thought he would faint; panicked, he would quickly lie down. A particular softness and tremendous suffering that I could see in his face brought about in me an immediate desire to help him.

By discussing this case, I would like you to understand the difficulty I face when I have a patient like Joël, for I always fear that I will find an irreparable psychic break. When I encounter such a touching and sensitive child, I am taken by a secret fear that I will find in him the monster that is insanity. From the first interview, I have an imperative need to know if his inner being is broken, or if it remained intact. For me, patients that have mental trouble are schematically divided into two large categories. There are those that suffer because an internal mechanism is broken—I am thinking of psychotics—the mechanism of rupturing is what Lacan called "*foreclosure*." There are those that suffer while nothing essential is wounded—I am thinking of neurotics—the mechanism at work is "*repression*." This is why I was profoundly concerned that I might discover in Joël the beginnings of a psychosis hiding behind his phobia of school. I live with the same unease as an oncologist, who, when examining a patient with care, looks for a tumor with the hope of never finding one. This is the same attitude I adopt: I draw upon all of my knowledge of psychoanalysis in order to discover a fault that, with all my being, I do not want to find: the psychic fracture. To discover a psychic fracture in this young man, to discover that he suffers from a burgeoning schizophrenia, would be to recognize the beginning of a drama that could last his entire life, a life of a martyr. I should tell you that with Joël, I was relieved to discover that his suffering was not one of an irreversible psychosis, but of a phobia, albeit a serious one.

If you asked me, "But how did you know that it was neurotic phobia and not a latent psychosis?" I would tell you that I knew it by posing certain questions to Joël—simple but precise. For example

I asked him: "Can you concentrate when you study?" He affirmed, "Yes, I have no problems, but occasionally I freeze up and my mind goes blank." And then I insisted, "But when this happens, or if you must make a huge effort to understand what you read, do you feel pain in your head? Do you have pain in your neck or the top of your back?" He replied, "No."

Waiting for his denial, I was reassured. If, for example, Joël had responded that he had to force himself to concentrate to the point of having a headache while showing me where he had the pain, and if he had talked to me about his suffering, that would have been for me the first suspicion of a burgeoning psychosis. Why? Because one of the first indicating signs of a schizophrenic formation is an enormous difficulty concentrating, accompanied by a hypochondriacal pain, that is to say an imaginary, hallucinated, pain, which young patients often locate around the neck and top of the back.

To eliminate my concerns, I further asked, "When you look in a mirror, do you sometimes have the impression that your body is changing, that your face is no longer yours or that your nose is deformed?" He replied, "No." So I asked further, "And your hands? Do you sometimes have the impression that they have changed?" "No," he assured me. If on the contrary, he had said, "Yes, sometimes I look at my hands and they seem strange to me," that would have indicated the beginning of depersonalization, the first step toward the diagnosis of an embryonic schizophrenia.

If Joël had responded in this way, I would have had to inform his parents of the extent to which they would have to attend to their son's needs and that I would need their cooperation to help him get better, since the participation of the parents is indispensable for the treatment of young psychotics.

This is how I approach a case of psychosis. But, as you may well imagine, in everyday practice, I would not formulate a diagnosis until there had been many meetings with the patient.

You have asked me about the role psychoanalysis plays in the treatment of mental suffering. It depends on the type of problem to be treated. Recall the distinction that I proposed between two types of suffering: One in which the psychical apparatus is out of balance but intact (neurosis), the other in which it is damaged (psychosis). Of course, psychoanalysis is a treatment that is most effective when the psychical apparatus remains intact, but when the soul is broken,

the analytic cure is a necessary complement to a medical treatment, including inpatient care in an institution. That is how the combined action of individual and familial psychoanalysis, with medication and hospitalization, came about as the best therapeutic strategy for patients that have succumbed to a painful psychical fracture.

HOW DOES ONE CHOOSE A PSYCHOANALYST?

The public is often confused by the different kinds of mental health professionals. How do we distinguish between a psychologist, a psychiatrist, and a psychoanalyst?

It is true that for the average person the distinction between the three is not always easy to make. I can tell you that a psychologist is a person with a university degree in psychology. A psychologist can work in a number of sectors, such as schools, businesses, and general hospitals, as well as mental hospitals, prisons, and nurseries. He or she can also see patients in his or her office and practice various methods of therapeutic treatment, including psychoanalysis.

The psychiatrist is a medical specialist with a medical degree. A psychiatrist is a doctor who cares for psychotics, depressives, or neurotics in an inpatient or outpatient environment. Psychiatrists can prescribe medication and can also choose a "talking cure" according to the principles of psychotherapy or psychoanalysis, but need not necessarily do so. I will add that there are doctors who have pursued degrees in higher education who may have no relation to psychology, but they can later train in psychoanalysis and treat people accordingly. But whether or not one is a psychologist, a psychiatrist, or a practitioner from another subfield, they cannot practice psychoanalysis except under the following conditions: they must have completed a personal analytic treatment, have thoroughly studied the fundamental psychoanalytic texts, and discussed the application of psychoanalytic theory with a senior colleague who oversees and guarantees the quality of work with the patients. Note that a psychoanalyst is one of the rare professionals who during the first ten, or perhaps even twenty years of activity must present each week to a supervising psychoanalyst and give a detailed account of the treatment he or she carries out with his or her patients. Psychoanalysis is a therapeutic practice

that can be exercised by a psychologist, a psychiatrist, or any other professional who has satisfied these conditions.

I have just said psychoanalysis is a therapeutic practice, but be aware that it is not a medical one. A psychoanalyst is certainly a clinician who is attentive to psychological and somatic symptoms when these express psychical conflicts, since he or she knows the extent to which the body notably echoes the unconscious. Nevertheless, somatic symptoms are not studied in a medical sense by a psychoanalyst. The psychoanalyst does not prescribe psychotropic medication, even though he or she knows the uses. His or her knowledge of medication, albeit incomplete, permits him or her to speak a common language with other health care professionals for example, when treating someone who needs hospitalization. I insist that psychoanalysis is not a field of medicine, but many of our patients also follow a medical treatment, which obliges us to know about the latest pharmacological research.

And yet, beyond the therapeutic activity, psychoanalysis has always been influenced by multiple cultural and social movements. For a hundred years it has not ceased to influence the domains of art, literature, philosophy, and sociology. Psychoanalysis has definitively left its mark in the field of education by helping us better understand child psychology, and it participated actively in the elimination of insane asylums by recognizing the dignity of the mentally ill.

So then what is the commonality amongst the various aspects of psychoanalysis?

I can answer without hesitation: it is the unconscious. As long as there are humans involved, so too will be the unconscious. Why is this? Well, what is it to be human? The singular trait of the human being is not speech, thought, or laughter, but that he or she is powerless at mastering the forces that act on the person from within, whether beneficial or harmful. The forces that elude us, and that exceed our will and our conscious knowledge, all fall under the heading of the unconscious.

And so, the proper work of psychoanalysis is to be concerned with the unconscious when the unconscious makes us suffer, that is to say, when the difference between who we are, and that which exceeds us, makes us unhappy.

You describe the vast influence of psychoanalysis, but what are its limits?

I will remind you that above all, Freud defined psychoanalysis as an investigative process of psychical life, a therapeutic method, and a theory that results from these practices. Of these three facets, it is above all the therapeutic method that demonstrates best the success and the limits of psychoanalysis. I have had the satisfaction, as have many of my colleagues, of treating many patients whose often serious problems definitively disappear. I have received many letters from former patients that tell me of a marriage that was previously unimaginable, the birth of a child much awaited, and many other testimonies of the efficaciousness of the psychoanalytic cure! Incontestably, psychoanalysis is an excellent way of easing suffering, but like all techniques, there are constraints for those who undergo it.

What constraints?

The constraints that frequently give rise to three main complaints, the first being: "Psychoanalysis is a *long, expensive,* and *painful* treatment." In effect, an analytic cure *can* last several years, but that depends on the relationship between the analyst and the analysand. For my part, my adult cases last two to three years. When couples consult me regarding problems they have living together, I schedule a series of successive sessions spread out over a period of about six months. If it concerns a child, I prefer to limit the number of visits as much as possible. This prevents the young patient from becoming so excessively dependent that the analytic relationship would replace the necessary familial dependence. The treatment of a child, if recommended, would last on average between six months and two years, depending on the severity of the symptoms.

The second complaint against analysis concerns the cost. On this point, I know that to undergo a treatment requires a significant financial commitment. Even though our rates are often adapted to the patient's ability to pay, there is still the difficulty of budgeting for two sessions a week. But such an expense pales in comparison to the vital importance of what brings someone into therapy: self-defeating behavior, sexual trouble, marital problems, difficult relations with a child, depression, etc. One must understand that analysis is sometimes the last resort for a desperate person, and that

the possibility of a cure is crucial for the person. Also, do not forget that there is help for those without resources at open clinics and other open institutions.

The last critique is that of the painful nature of psychoanalysis. Without a doubt, the patient goes through periods of intense emotion and can leave the session quite upset. Without a doubt, analysis has moments when memories are painfully relived, and you can imagine that no one could bear the treatment if all the sessions were painful. We can also say that we share moments of happiness with the patients, and we sometimes laugh together, in the moments when it is a pleasure to reconstruct their history, take account of progress to date, or imagine the future.

If the relationship between patient and therapist is this powerful and intimate, then the choice of the psychoanalyst is crucial. What advice can you give others in finding the right person?
It is a question people often ask me. When we measure the intensity of the engagement that psychoanalysis entails, one must indeed take the greatest care in choosing a therapist. How *can* one proceed to find the right therapist?

I can begin by stating what one should *not* do, namely, to choose a therapist based on the school to which he or she belongs. In all groups there exist good and bad practitioners. I can be critical of a school of analysis, and at the same time recognize talented practitioners in that school. As I see it, the personal qualities of the therapist are infinitely more important than the school of thought to which they subscribe.

Apart from this concern, what is then the best criterion for choosing a psychoanalyst? I will tell you that the best path is simply to go and consult with a psychoanalyst who has been recommended to you. Most importantly, evaluate the effects the first encounter has on you. Perhaps it will be necessary to consult two or three therapists before making a decision, but no more than that; one should avoid seeing too many (I have known of people who saw up to eight!). This has an impact on one's ability to judge, because on the third or fourth attempt the patient is accustomed to telling his story and becomes desensitized. The patient loses the spontaneity and anxiety that is appropriate to the success of the first encounter.

The best criterion on which to make a decision as a future patient is based on the impression one has at the very first encounter with the psychoanalyst. One must feel relieved and confident, while noting that the therapist was able to articulate clearly what I was feeling in a confused manner. What follows is what determines the best therapist for someone: the secret conviction that the psychoanalyst has understood me and is ready to help me. In a word, the feeling that the therapist I just met had already helped me. Thus, leaving the preliminary session, patients tell themselves, *"I already feel better. This psychoanalyst has given me hope and has given me the strength that I need now."* The patient does not say, *"It is him or her that I will choose,"* but rather, *"I have the desire to see him or her again because I sense that my life's path will be changed."*

Now, in order to create an environment for this kind of good will, it is preferable that the therapist speaks in the final minutes of the initial session. I counsel all of my students to conclude the first session by communicating to the patient the deep significance of what was heard. It is indispensable, before the end of the first session, to reformulate in different words the substance of the complaint that one heard from the patient. Indeed, we should show the patient that his or her way of interpreting his or her suffering is perhaps not the most adequate, and that there is another approach. I have found these parting words on the part of the psychoanalyst the best way of welcoming the patient while establishing a productive transferential relationship.

In sum, the best criterion for finding the right psychoanalyst is to experience right away the clear desire to return to see him or her again.

But is psychoanalysis a valuable method for everyone? Who is analyzable and who is not? And why?

The topic you bring up, of "analyzability," has often stirred up the analytic community. I will tell you the substance of my position. First of all, know that psychoanalysis is not a method that can be applied to everyone; it is not the case that everyone can be analyzed. What then are the conditions of analysis, and what is the profile of a person who is open to the benefits of this treatment? In order to be analyzed one must meet certain conditions. First, the man, woman, or child must be a subject who suffers beyond what he or she can

bear. In addition, they must complain about this fact. The complaint is crucial. Second, it is someone who asks why they are tormented to such an extent. That may seem elementary, but it is decisive. In order to be analyzed, one must ask the question, "Why do I suffer? Why am I doing so poorly?" And one must attempt to find for oneself the answer to the question. The third condition is precisely that attempt to explain one's suffering.

To suffer, to ask about the cause of the suffering, and to try to understand it, are the necessary conditions for a true engagement in an analysis. But there are other conditions that are just as important. It is also necessary that the person seeking analysis believe that the psychoanalyst holds the key to understanding his or her problems. This belief is fundamental, because it is synonymous with hope, and as we know, hope is one of the forces that drive the cure until the pain is eased. From a theoretical point of view, Lacan has synthesized this confidence in the analysis and the psychoanalyst in an eloquent formula: "*Sujet-supposé-Savoir* [Subject-supposed-to-Know]." We can modify this expression with "the psychoanalyst-supposed-to-know," a psychoanalyst that we think is sufficiently competent to help us find a way out. The patient expects his or her recovery with a psychoanalyst, who is believed to be capable of achieving said recovery. To expect is already to believe that there will be a happy ending. Everything hinges on the belief that the therapist will know how to respond. You see, it is only as a result of the promise of my healing the patient—a promise that in fact the psychoanalyst has never actually made, but I imagined was made—that the treatment can then begin.

The last condition of analysis may surprise you: it is a matter of anxiety. In fact, even if that seems curious to you, it is necessary that the person seeking treatment hesitates to confide and is wary about getting involved in analysis. Yes, one should have anxiety and fear of confiding. Without that, psychoanalytic action would have no chance of being successful.

Let me explain by describing an initial consultation I had where this fear was missing. Recently I received in my office a well-known businessman. He was around forty years old, elegantly dressed, and arrived at my office in a chauffeured limousine. Immediately in the waiting room, without the least hesitation, he started talking loudly on his cell phone. Later, when he entered my office with a self-assured air, he sat down on the chair with the arrogance of someone who

fears nothing. In a businesslike tone, he proceeded to speak of his interest in receiving practical advice and counsel. My first words to him were designed to establish the boundaries of our relationship, and to ask that he not use his cell phone in the waiting room:

"The next time, when you are waiting, I prefer that you sit and meditate. When you open the front door, I ask that you inhabit the space as though it is your own internal world, as if when you pass the threshold you are no longer in an office, but in a dream. It is as if you are dreaming. Imagine that it is the moment when you go to bed and turn out the lights. It is this instant, this brief moment of time between waking and sleep that I want you to relive here. As such, when you arrive next time, peacefully find a place to sit and try to collect yourself."

Of course, I formulated the remarks in a cordial and respectful tone, and he received them well because he was presumably looking for just such an act of authority. By coming to see me, he was hoping, without knowing it, that someone would speak to the child in him, apart from his social position.

You can see that the lack of anxiety, I mean, the cavalier attitude of the patient, is a stumbling block to analysis. It was for this reason that I proposed a limited series of sessions without inviting him to lay down on the couch. I waited for the time, however many visits it would take, for him to ask, *"Doctor, why haven't you asked me to lie down on the couch?"* I told him that one must be patient and the couch would be recommended depending on the evolution of the discussions. In order to be able to lie down, the patient needs a certain capacity to go into himself and become aware of the drives of his internal life. There are many people who do not know or cannot meditate on their internal life, and instead are always focused on the external. This leap into oneself is a very difficult exercise for people of action, while other patients who may be manifestly more anxious, know how to question themselves. For those who are conscious of their unhappiness, the couch remains the most effective method.

On the subject of those who go to a psychoanalyst, I would like to point out that the majority are motivated by their difficulties, not by a desire to be analyzed. It is an error to think those who seek help explicitly want an analytic cure. Above all, they are most concerned with being rid of their unhappiness and not with the methods used, whether it goes by the name psychotherapy or psychoanalysis. What they want is not to suffer anymore. After the first few visits, it falls

to the psychoanalyst to adapt his or her technique to the particulars of each patient.

I would like to conclude with a lucid phrase from Lacan: "What people ask from us, we should say in the plainest terms possible, is happiness."

AIMANCE, OR THE NEED TO BE DEPENDENT

There is another criticism we make of psychoanalysis, that of creating and sustaining the dependency of the patient.
But analysis cannot even begin to take place without a relation of dependence! It is necessary that the patient has a desire to go to the appointments and be as intimate as possible; otherwise the treatment has no chance of succeeding. I know the contemporary view is that such a dependency has pejorative connotations, but in an analytic relationship the dependence of the patient is, on the contrary, positive, necessary, and I would even say, inescapable. It is impossible for a patient to voice his innermost secrets without being connected to the listener. And one is strongly attached to the person who helps one recognize the stranger in oneself. When someone helps us to go inside ourselves and discover a forgotten emotion, it is inevitable that he be loved. In sum, if a person confides regularly in another, it will lead to his being attached to the other. This is what I want you to see: the phenomenon of dependence cannot be disassociated from the content of the analytic relationship.

I would, however, like to add an important observation: any affective dependence, whether it is analytic or not, is a response to the primary need for attachment. In effect, our bodies are always hungry for another body and our souls thirsty for another soul. In youth, we all have been and have gone through an essential dependence to the nourishing mother. From our earliest years, we are driven by an imperious need to attach ourselves to somebody, to tie ourselves to a select few to whom we attribute the force of a protective authority. It is as if we are always moved by a healthy parasitic drive, by a propensity to take hold of another, and to confer on him or her a guardian power. We attach ourselves to him and apply our capacity to love, hate, or fear. Our lives are aimed at those special few, parents, professors, friends, partners, children, therapists, on whom we are

dependent because they let us love them, hate them, or fear them. I call the force that incites us to depend on another, the object of our emotions: *need of dependence*, *attachment drive*, or, more poetically, *aimance*. In this expression *aimance*, I have collapsed the words "*aimer*" (to love) and "*tendance*" (tendency) in order to designate the force that pushes us into the arms of our partners to the extent that we are dependent. I recall the spontaneous declaration of a young female patient who exclaimed, "I sense in me an overflowing love that only wants to go toward someone who I will make my master!"

Many times it has happened to me, while listening to a patient during the first appointment, that I will be able to measure the intensity of his or her *aimance*. Beyond the words used, I hear the patient tacitly inquire of me, "Are you available for me to love, hate, or fear? May I idealize you? Will you accept being honored one day and mistreated the next? Are you ready to enter my fantasies and play a role?" Without question, those who we solicit are drawn by an insatiable need to find a sentimental benefactor and attach themselves.

But I have also told you that affective dependence was necessary for the success of treatment, as it renders the patient more receptive to the interventions of the psychoanalyst. If the patient is not dependent, if the therapist is not idealized as an infallible elder, the patient will not feel sufficiently confident to free his or her unconscious.

That being the case, the psychoanalytic practitioner should master the spontaneous phenomenon of dependence, both in its intensity and duration. If the dependence becomes excessive or if the treatment goes on indefinitely, I would deduce that the therapist did not know how to direct the cure, that is to say, to maintain the right distance with his or her patient in order to avoid falling into a relationship that is as passionate as it is interminable. Certainly, such setbacks can be overcome; fortunately, they are not that frequent. Beyond these impasses, the fact remains that the dependence of the patient, properly directed by the psychoanalyst, is compulsory to all healing.

Is this attachment to the psychoanalyst the transference?
Absolutely. Transference designates all of the hostile and tender affection that bind a patient to his or her therapist. Throughout the sessions, the patient could love the psychoanalyst, feel protected by him, sometimes reject him, occasionally have sexual desire for him, include him in his fantasies or dreams, and at other times may even make