Lou Breger Interviewed by Jon Seirup

Jon: Lou, in your most recent book, Psychotherapy: Lives Intersecting, you came up with a unique idea where you contacted a number of patients from as far back as 25 to 30 years ago, and used the technique of psychoanalytic psychotherapy to discuss outcome. How did this idea come to you and how were you able to contact so many people from so long ago?

Lou: A very good question Jon. The basic answer is, I don't know how I came up with the idea. It just kind of appeared in my mind. But I've always been interested in the course of people's lives, how things go over many years: for example what happened to all of those friends I had in high school or as an under- graduate? How did their lives turn out 30 or 50 years later? So that general thought was in my mind, but I didn't plan this as a scientific study or a piece of research.

And how would I get in touch with them? Some of them lived at the same place that I had in my address book so I wrote them a letter, but the internet was really the main way. You can look up all kinds of people and get their email address. So I got in touch with them that way. Some of them I had stayed in touch with after they finished their analysis or therapy 20, 25 years earlier. So one way or another.

And then all of the actual work was done by email once we established contact. I asked them each the same question, "what, in your own words, was most helpful or therapeutic, or not therapeutic, in our work together? You can make you answer as long or short as you want and everything will be treated confidentially. Pick your own pseudonym. And we'll disguise any details that might give away who you are." And I think what's important about that question -- there is a lot of psychotherapy research but follow-ups are typically done with a more structured questionnaire where they ask a former patient a series of questions whereas my question was completely open. It's like therapy itself. What was helpful or not. Say it in your own words. Say it however you want. And that forms the heart of the book, Psychotherapy: Lives Intersecting.

Jon: Lou, did you find that when you talked to these people and got their responses back, that there were some common threads that ran through their answers, that told you about what they thought really worked well for them?

Lou: They clearly pointed to common threads. Once again, I didn't know in advance what was going to come out and even though I had moved a long way from psychoanalysis in its old form, I still had the idea that uncovering unconscious material, making it conscious, recovering forgotten memories, traumas and so on, would play a much more important role then it did. As it turned out, that kind of thing was down in the middle of the list of what patients remembered. What they did remember as being most therapeutic, most helpful, were relationship factors. As one reviewer of the book said, "the relationship rules." And what were the relationship factors? Listening closely in a non-judgmental manner, being friendly, their feeling that talking to me over time was increasingly safe so they could say whatever they wanted. Also, catharsis: the ability to express openly a whole range of emotions as they felt them. Another important factor was repairing mistakes after I made them. That is, we all, however good therapists we are, we all

screw up from time to time and the thing to do, and what patients remembered, was when I would make a mistake -- let's say I forgot an appointment and didn't show up and the patient was there, and was angry about it -- I would say, "I apologize; it's my fault; I had some things going on in my life that were upsetting to me and I forgot to write the appointment in my book. It was not your fault, it was my fault." And the patients would report that was really helpful to them and they could then go on. I would sometimes blunder as any human being does. Humor was also mentioned by several patients, though it was appropriate with some but not all. That is, being able to laugh together about something that happened that was funny, kidding around from time to time, not making therapy a deadly serious, somber business, but giving it a kind of light tone. These were some of the common threads that ran through the responses to my query.

Jon: So would it be fair to say that you retain some aspects of the formal or traditional psychoanalytic methods but, can you tell us what are the essential differences between psychoanalytic psychotherapy and psychoanalysis per se, and why as an analyst yourself, do you prefer this new mode of intervention?

Lou: One must distinguish between old and contemporary psychoanalysis. Old psychoanalysis -- classical, Orthodox, Freudian û maintained that the analyst must remain neutral, abstinent and anonymous. They were often stiff, silent and authoritarian. This is the caricature that you see in a Woody Allen movie, the analyst who sits there, never says anything, the less he says the deeper it supposedly is, he is a blank screen on which patients supposedly project their unconscious conflicts. That kind of analysis is useless if not damaging to patients. Several cases in my book came to me after seeing old-fashioned analysts like this and talked about how they saw this person for several years and he almost never said anything or what he did say was not helpful and how seeing me, they found so much different û that I was human, friendly, warm, supportive, said things to them that gave them the feeling that I really cared about them, which was true. That's a key difference between old and new psychoanalysis or what I would call contemporary psychoanalytic psychotherapy.

Jon: Earlier in your writing career in the 1970's, in earlier books like, From Instinct to Identity and The Effect of Stress on Dreams, you began describing some of Freud's key ideas through your own research and findings. How much do you feel that Freud has ultimately influenced your therapeutic style and how much of your technique doing contemporary analytic psychotherapy is a result of your many years of actually doing therapy and learning from your patients?

Lou: At the beginning of my career, I did critical work on Freud, but mostly on his theories. My early papers looked at his ideas, his theoretical ideas, and I began seeing things that were wrong with them and criticizing them and that was, for example, behind the work in The Effect of Stress on Dreams, which is a book that came out in 1972. Among other things, I abandoned the idea of "latent dream content" and found that dreams were symbolic attempts to master current emotional conflicts. The dream is what it says it is, if you know how to listen, so Jung was closer to the truth than Freud about this. But I was also isolated at that time, teaching at the University of Oregon in the small city of Eugene where there wasn't a psychoanalyst within 100 miles.

Also, I was never in therapy at that time, being a very uptight over-controlled kind of guy. Yet, I maintained the belief that, while there were a lot of things wrong with Freud's theories, being in psychoanalysis, four times a week, lying on a couch, was probably the deepest and the best kind of therapy available. And, when I moved to Los Angeles in the 1970s, I took training at one of the classical psychoanalytic institutes and went into a training analysis five times a week for over four years; this was when I experienced psychoanalytic therapy first hand, learning what psychoanalysis really was in practice. I was with a group of other candidates that were going through the program, and we were all in analysis and we'd talk about our experiences. And I came to see, more and more, that orthodox or classical analysis really didn't do many people much good and, beyond that, that it was damaging to a number of people. So I moved more and more away from that in the cases I treated. And, by the 1980's I really was doing a contemporary relational kind of psychoanalysis.

Jon: Did you work with seriously ill patients and would you say that new psychoanalytic psychotherapy is the most effective method to assist folks who are suffering deeply and therefore experiencing a poor quality of life?

Lou: I have, over all the years of my practice, been open to seeing anybody who wanted to come in as long as they would appear, pay the fee, and get engaged. So I've seen a range of people from mildly or moderately disturbed, to some -- a smaller number -- who were very seriously disturbed. I can think of one young man I saw in the 1970's who suffered an extreme form of anorexia, bulimia. He practically looked like a skeleton and he also engaged in compulsive exercise, working out for three hours every single day. Plus, he had a lot of bizarre ideas about what this all meant. Then there was a young boy who I started seeing when he was 14, and saw for many years, who had such an extremely high level of anxiety that he could hardly leave his room where he soothed himself with fantasies. I've seen people at that end of the spectrum: highly disturbed. I also saw a number of people in the middle range, as well as people who were in an analysis that was part of their training in the psychoanalytic institute who were well functioning, who had the normal range of problems like me and you and many others.

Jon: And so you found that your way of doing therapy and intervening with people from all aspects of life was effective based on the values that you were able to convey to them that you listen well, and you show that you genuinely care about them over time?

Lou: I think those are the crucial ingredients. You have to develop a real relationship without a big power difference between therapist and patient. The book itself has a lot of long verbatim quotations from the patients themselves in which they talk about what they experienced as most helpful. For example, one woman in the book, who calls herself Christine, says, "I finally stopped hating myself because I came to believe that you really liked me." And she gave an example. There was a time when I was hospitalized with a stomach bleed that finally got better but at the time I was in pretty bad shape, and she checked with my wife and found that it was okay to call me in the hospital and see how I was. And she reported, "When I got you on the phone, you sounded genuinely pleased to hear from me." And she thought to herself, "well he's lying there in the ICU on morphine. He could not fake that tone in his voice, he must really like

me." One of the things that is significant about that is her noting the tone in my voice. She picked up the emotional quality, it wasn't just intellectual. And I was genuinely pleased to hear from her and I did like her and still like her. And that was, for her, the crucial thing in changing the way she felt about herself.

Jon: Do you feel that potential clients or patients seeking therapy have to be psychologically minded and highly intelligent and extremely motivated in order to benefit from your way of doing therapy?
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Lou: I don't think so. I think it certainly helps if a person is what we call psychologically minded, that they can think about themselves and take a step back and not be completely caught up in their anxiety or depression or what have you. But, once again, I've been willing to see anybody. I don't see people who are mentally retarded or are seriously diminished developmentally, but you know, anybody with average intelligence can benefit from psychotherapy if they're willing to get engaged and look at themselves and try and work on the things that are troubling them.

Jon: Do you feel that people have to be in therapy for a long time or be seen more than once a week in order to receive meaningful assistance?

Lou: By no means. I think the kind of deep changes that occurred in a number of these patients, were only possible when they came for a long time. On the other hand, years ago I and some colleagues set up a program at the UCSF Psychiatry Department in brief psychotherapy where we saw people for a maximum of ten sessions once a week and I was amazed at how some people could get a great deal out of this very brief contact. Some of them got engaged enough that they then went out and sought additional therapy and could continue the process over time. But you can accomplish certain meaningful things in a short period. And there are some people I've seen for a great number of years.

Jon: Well some people are of the mind that behavioral change is the most important thing and all that is needed is to punish bad behavior and reward good behavior in order for people to make changes. What is your opinion about that and wouldn't that form of intervention be cheaper and take less time?
Lou: You're referring to behavior therapy, or, as it is now called, cognitive behaviorial therapy or CBT. No, I don't think rewarding and punishing good and bad behavior is an effective way to help people deal with their psychological and emotional problems and make lasting changes. In fact, the first major publication that I did was a paper in 1965 titled Critique and Reformulation of Learning Theory Approaches to Psychotherapy and Neurosis, which I co-authored with a research colleague, James McGaugh, whose work was in learning and memory. We discussed what was then called behavior therapy, which was all based on rewards and punishments. And, in that paper, we took apart all of their claims and showed that they were not consistent with the best scientific evidence, that their claims that their therapy was successful had little substance. More recently, CBT is touted as the treatment of choice because it is "evidence-based,"

supposedly quicker, and cheaper. HMO's like it and the government likes it because they don't have to pay much money for it. However, there is a lot of research going on now that shows that CBT works best when it combines the elements of what we would call psychodynamic or psychoanalytic therapy. CBT is done from manuals that prescribe exercises on how to get over symptoms. But the new research shows that it works best when it's done in the context of a warm and accepting, friendly relationship. If it's done in an impersonal way, by a CBT expert wearing a white coat, it is experienced as robot-like, sterile, impersonal and uncaring and, therefore, tends not to be effective and long lasting.

Jon: Lou, if we accept the premise that having a lot of formal training and education may not necessarily be the best criteria for choosing a therapist, what might you suggest are the most important factors to optimize the chances for healing and growth.

Lou: It's a difficult problem. If you're really hurting emotionally and you need to pick a therapist, how do you know which one to pick? If you're in the field, like you and I are Jon, you can ask around to different colleagues and get recommendations. But if you're not, if you don't have any connections, how in the world do you do it? I would say get some recommendations however you can, go to see a few therapists, and then trust your instincts. If you feel comfortable talking to a person, that they're listening to you, that they're answering questions if you ask them, then try working with them. A good fit or match is crucial. If it feels off, it they feel stiff and too formal and they don't seem to get what you're talking about, try somebody else. So do some shopping and, once again, trust your own feelings about whether this is a person you feel good about talking with.

Jon: And what role do you believe medication plays and is the combination of medication and psychotherapy a better mode of treatment for something as prevalent and common as depression, than cognitive behavioral and, if so, why?

Lou: This is an area where I've actually followed a bit of the recent research. And what this research shows is that treatment is optimized and most helpful when psychiatric medication -- whether anti-depressants or anti-anxiety drugs û is combined with psychotherapy. If you just give the meds alone, it seems to be the case that they don't do much better than placebos. So it's pretty clear from the studies that I've seen that a combination of medication with psychotherapy is your best bet. Now, in my practice, I don't routinely prescribe or recommend medication but there have been some people who, in their therapy with me, have also gone on medication and found it helpful and some of them have stayed on it for a period of several years. So again, to answer your basic question, I have indeed found that a combination of psychotherapy and appropriate, medically supervised medication, leads to the best outcome over time with certain patients.

Jon: And how well must a person be trained and what do they need to know in order to effectively deal with someone who is homicidal or suicidal as a result of depression?
Lou:It goes back to a question you brought up earlier that I don't think I answered, which is how much training do you need to be an effective therapist. I think training is extremely important. I

also think one's own therapy is important, in fact crucial. I think supervision with a good supervisor is important too. But, having said all that, I think some people are born with a therapeutic touch and some people are not. It's like any gift or talent; it's given to you but you are the one who must develop it. I know this to be true of myself. According to a lot of these former patients, I turned out to be a pretty good therapist. It's just something that, once I started doing it in graduate school and began to see patients, it felt that this is what I was meant to do as a career in life. It felt natural, it felt right, I enjoyed doing it. Having supervised a great number of people over the years I would say there are some that are like that; even at the beginning of their training, when they haven't had much background, they are good with patients. They have the touch. And there are others, it doesn't matter how much training they have, and how much supervision they have, they are kind of hopeless. There are some well-known, even famous analysts, who are not worth a jot.

Jon: So would it be fair to say that during your career, you've known some analysts and therapists who are extremely well trained and gone to very prestigious schools, but its almost dangerous that they are out there practicing?

Lou: Absolutely, yes they just don't get it and they never will get it. And some of them are actually quite harmful to patients. They hook patients in and see them for many years and the patients never get better. As to your question about homicidal and suicidal patients, I don't know that I've ever seen anybody who was homicidal but I have seen a number of people who have talked about killing themselves. One of the early cases in the book is a man, who calls himself Andrew, who was in his 40's when he came to see me and he had been seeing two more orthodox psychoanalysts for a period of six months and nine months right before coming to see me. His depression was set off by his wife leaving him for someone else. He had had a lot of therapy over the years. And he was, indeed, quite seriously suicidal. He was a very smart man and when he talked about it he wasn't just putting me on or it wasn't a temporary mood, he was seriously contemplating it and had it all worked out how he was going to do it so that it wouldn't appear to be a suicide so his kid wouldn't be deprived of his life insurance. So it was fairly scary. However, we developed a good connection and he had a very successful analysis with me. He was one of those who, in response to my query, talked about what was most important was a friendly accepting relationship whereas his two previous analysts were silent and made classical analytic interpretations about his childhood traumas, his supposed complexes, and so on. In our work, we focused mostly on how depressed he was about his wife leaving him for someone else which is something that had just happened in his adult life, because that was why he was depressed and thought of ending his life. Over time, we explored a lot of other aspects of his history. He remembered a couple of incidents from early in our therapy that he used to illustrate the difference between his previous psychoanalysts and our work. One time he had drank too much the night before and woke up with a terrible hangover and he came into the session and, as he was leaving, I said to him, "and don't drink too much tonight." He felt that to be a kind of thing that one friend might say to another; don't give yourself such a terrible hangover. Another thing he remembered was a time I gave him some chocolate chip cookies and I said, "my wife baked these for you." Now I don't think I've ever given cookies to any other patient in all the years of my practice. I did it in this instance because he had had a memory of someone giving

him some cookies as one of the very few happy memories from a pretty bleak childhood and so, by doing this, I thought it was a friendly gesture that would be meaningful to him. He talked a lot about my "humanity" and contrasted this with the uptight, formal, ineffectual psychoanalytic techniques that he had been exposed to before.

Jon: Well you certainly seem to have manifested your humanity also in your definitive biography, Freud: Darkness in the Midst of Vision and its companion piece, A Dream of Undying Fame. Would you say that Freud himself suffered a great deal and probably could have benefited himself from some very good probing psychotherapy?

Lou: Very much. In my biographies I tried to present an objective, fair, and balanced picture of Freud. There is no question that Freud was a brilliant man who made some enormously important contributions. All of us who practice therapy really owe him a debt because he started it all. At the same time, his theories and treatment methods are full of wrong-headed ideas that he insisted people adhere to if they were going to be psychoanalysts. In my study of his very sad early years, Freud was powerfully traumatized by early maternal losses, which we now know can be devastating for healthy development. When he was a very small child his mother quickly gave birth to another baby boy. So Freud lost her exclusive attention in those tender early childhood months. To compound his loss and deprivation, the new baby died eight months later, so he lost her a second time, first by being ursurped and replaced and then, to her grief over the death of this baby. And then in quick succession, five more sisters and a brother were born, so that by the time he was 10 years old his mother had been pregnant seven times with five living siblings, plus him. He also had a nurse whom he was deeply attached to who was caught stealing from the family and fired; she vanished from his life when he was 2-1/2 years old. Then, in his so-called self- analysis, he got very close to these buried traumas, these losses. And it was far too much for him, too painful. He couldn't bear it so he turned away and, with his great intellect, substituted his theory of the Oedipus complex and the importance of sexual drives and fantasies. This was the crucial turn in his thinking and the development of psychoanalysis as a form of therapy. It was a turn away from his own painful early traumas to a theory that ignored reality in favor of drives and fantasies. This gets back to your question of why he would have done well if he had a good contemporary therapist or analyst to work with him on this; they would have focused on what really happened in his earliest years.

Jon: Indeed, one of the most striking things about both of your biographies of Freud, is the fact that throughout both of those books you're entirely non-judgmental and in no way critical of him in a negative way. Do you feel that carries through also in the way in which you yourself do therapy with your patients in the sense that you are not, in any way, critical, directive or judgmental?

Lou: Absolutely. And I know the patients whose reports make up the contents of this new book talk about how I listened to them in a non-judgmental way, that is the very words that they used. And you're right to bring that out Jon. I try and look at Freud as if he is a patient also, to be treated with compassion and empathy. I am not there to judge him or demonize him. I think he was an absolutely brilliant man and writer and very persuasive, with many essential ideas that we

still rely on today. At the same time, he was obsessively driven towards fame. That is why the second book is called, A Dream of Undying Fame. There is a quote from Freud in which he talks about his quest for "eternal fame" that, in my view, is incompatible with being a good therapist. You can't be there for your patients and their needs if you want to work with people so you'll be famous. It's not good for patients if your main goal is to win the Nobel Prize.

Jon: To go on a little bit of a different tact regarding hidden agendas, for yourself, do you ever feel that if you have erotic feelings about a client and is there ever an appropriate time to share such normal human feelings with them?

Lou: That is a very tricky business, a minefield really. Certainly, over the years of doing therapy I have had erotic feelings towards women patients and I think it's a great danger if you act on those feelings and that would include even talking about them with the patient. You encourage the patient to talk about their erotic feelings for you in this context, they should be able to say anything and everything that they feel openly and know that they are not going to be condemned or judged for it. But I think if you say to a woman patient, "you are really looking attractive today" or "that's a very sexy blouse you have on" you're crossing a line, flirting and encouraging them towards sexually acting out which is damaging to patients. We should be there to emphatically keep them safe, do what is in their best interest and welfare.

Jon: So your patient's safety and welfare is upper most at all times regardless of how casual and friendly you might be?

Lou: That's right, that's right. It brings out a good point which is that being friendly doesn't mean being casual or just saying anything that you might say to a friend at a party or over lunch.

Jon: Is it ever appropriate to engage in a social engagement with a patient, and if so, do you maintain a partition between professional and social life?

Lou: What I have found is it's not a good idea to get socially involved and have friendships outside of the therapy early on. As the therapy goes on for a number of years, and when it's over, with a few of my patients, we have become friends and, just like with any other friend, we keep in touch, we share interests, send each other books that we've enjoyed, talk about movies that we've liked, recommended ones they might like, and so forth. After all, there has been a close, trusting relationship, unique and like no other, and we sometimes have shared interests. With a large percentage of the people that make up the sample in this new book, many of them have kept in touch with me after the therapy has ended by sending me a once a year Christmas card in which they have pictures of their kids so I can see them getting bigger every year and a brief note about how things are going in their lives. So there are degrees of social interaction after the therapy is over. I haven't found it useful when the therapy is going on to go out to dinner with the patient or to have social interactions, with a few exceptions. For example, you work with a patient for several years and they decide to get married and they invite you to their wedding. Do you go? I would almost always go, or to their kids' bar mitzvah, or similar situations. But then I am just one person in the audience at the wedding and go up and say congratulations when it's

over but I don't get involved in extensive social interactions.

Jon: You mentioned earlier about talking to your patients or disclosing to them some very difficult and painful surgery that you had, what are your thoughts and feelings about actually revealing personal aspects of your own life and what are the potential problems with this and how have you handled it?

Lou: By and large, here is what I have come up with; I call it the new fundamental rule. Freud's fundamental rule was free association, namely that you say anything and everything that comes to mind without censorship. My new fundamental rule is you can do a lot of different things in therapy if it's always for the patient's needs and not your own. That's my guideline. So, for example, talking about yourself or your own problems; if you're doing it because you need to talk about your own problems, you're switching roles and trying to make the patient into your therapist and I think that is a big mistake and unethical. It is not good for people. But there are times, when, let's say a patient is talking about something that they feel terribly ashamed of or embarrassed or inadequate about and it may be helpful for me to say, "well you know I went through a very similar thing myself and I know how ashamed it It made me feel and so I can understand how you feel," something like that. It's for their needs. It's not because at that moment I need help with my shame or embarrassment.

Jon: I see. In your most recent book, Psychotherapy: Lives Intersecting, you stress the importance of the match or fit between therapist and patient as a crucial component to a successful outcome. How do you know whether you and the patient are a good match at the beginning and what do you do if you sense that you are not and can you work with patients if your personalities clash, if you feel the relationship will go poorly for both parties, how do you handle this?

Lou: Again, that is a very tricky business. Basically, you have to trust your instincts, trust your emotional reactions. And I do believe that I've been open to seeing just about anybody who wants to give it a try but there are some people that were just not a good match. Now it doesn't mean that we have to share political or religious views, that isn't what makes a really good match. My own feeling is if somebody is serious about getting engaged in the therapeutic work and working on their problems, and they feel like I'm somebody they can talk to comfortably, be at ease and develop a sense of trust with, then we are a good match. They may be a super right wing Republicans or have some views that I think are absolutely ridiculous, but that isn't what therapy is about. It's not a political debate and I have worked with people who have very different views than me about a lot of things, different tastes, different goals in life, and different belief systems. If they're willing to get engaged and feel like I'm somebody they can comfortably relate to, then we are a good match. And I think the match or fit between us is a crucial thing. If I can go on with this a bit. In the Freud books, the two biographies that you mentioned, I review a great number of his own cases, including the famous cases that he published long accounts of, and also other patients who have written their own books about their analysis with Freud, and people who were interviewed about their experience with him, and it's quite interesting that the cases that he was most successful with, which are ones that he never

wrote about, were ones where there was a good match. Now what was a good match for Freud? Well, you had to revere him as a great genius and never disagree with him and not challenge him on the certainty of his ideas and then he could relax and be an open and a helpful therapist with you. And there were some people, like a young man named Albert Hirst, who first saw him when he was 16 and thought, "Boy, Freud is a genius and anything he says is going to be the word of a genius!" so he was the least likely person in the world to ever challenge Freud or give him any trouble. And Freud basked in that admiration and he was very open and friendly with this young man, talked with him, didn't follow any of his rules of abstinence and neutrality and the like. And it was a very successful analysis, extremely so.

Jon: Psychotherapy doesn't work for everyone. Can you give some examples of failed cases and explain why you think you were not able to be more successful?

Lou: I have a whole chapter in the new book called, When I Didn't Help, which is about failed cases. I would have liked it if more of the people that wrote back in response to my question, contained more negative cases so that it would be more balanced, but there were two who did write back. One of them was a man who is called Karl in the book, and he is somebody who, for about 40 years, had seen one therapist after another, and none of them could help him. And we started out okay but, lo and behold, I turned out not to be able to help him either and I think in his case it had become his identity. He's the man that no therapist can help. The other was a woman who had an autistic kid that was very successfully treated by behavioral methods. She found working with me kind of interesting, but she said, "what's the difference if you find out what happened with you and your parents what's important is changing behavior." She had seen behavioral methods work with her autistic kid and she found my methods deficient in comparison to that. So in her case, she was right. Now there are several other cases that I talk about in that chapter where I think my own personal limitations kept me from being as effective as I could have. The book, by the way, is called Lives Intersecting, and the other life that intersects with the patient's is mine. I have some autobiographical chapters in which I talk about both my childhood and family and my professional biography, which are revealed in some detail. And, one of the things about me is that I tend to be a very emotionally over-controlled guy. With several patients that I talk about in the book, they got into describing extremely traumatic things that had happened in their childhood, and I think, because I was so controlled and cut off, I would press them to talk more about these things. And they got so anxious that they quit. So it was my limitation. What I should have done, with the wisdom of hindsight, is step back and told them, "look you don't have to talk about this all right now, we can take it a little bit at a time. I can see that it is freaking you out to get into it. Slow down we'll get back to it when you feel ready." I think if I would have done something like that, it would have been more helpful to them. So, it's an example of how my own personal limitations kept me from being as helpful with them as I might have been.

Jon: Did you find that you were able to then actually admit these mistakes and describe them as mistakes and talk them over with your patient or was it only in hindsight that you realized that this outcome was not what you would have wanted it to be?

Lou: They quit and never came back so I didn't have the chance to talk it over with them. I made some efforts to contact them and said, "would you come back for just one more session so we could talk about what went wrong," but they weren't interested in doing that. Ideally one does do what you describe, if you recognize it and become aware of it. I was not able to do it with those people and I'm not even sure, at the time, that I was aware of what was happening within me. It was really more in writing the cases up years later that I could see how my own limitations prevented me from being as helpful with them as I might have been.

Jon: Have you ever been fired, dismissed or told you are incompetent, uncaring or just a plain lousy therapist?

Lou: Sure. I remember one young man who came in for his first session and I used my standard opening line which is something like "what brings you here," or "where would you like to begin," and he went off into a long rant about "oh you're one of those Freudians who's never going to say anything to me. You don't know what the hell you're doing" and reamed me out and quit after this one session. And I've had some others who come for two or three sessions and never come back. It's quite clear that what I do, the kind of therapy I do, is not what they want and they don't like it and they let me know.
Jon: Well you've also had, have you not Lou, some very very wonderful relationships with people where there was a great deal of humor involved? As a matter of fact your current book, Psychotherapy: Lives Intersecting, is indeed the title. But it's not the title that you selected originally? I mean you had an experience that caused you to have a different title based on humor, is that not true?

Lou: You're the perfect straight man to set me up to tell one of my favorite jokes or funny things that happened. The original title was about vaginas and here's the story. I was seeing this brilliant writer and when he initially came in he demanded that I adhere to the strict rules of psychoanalysis as he understood them and not be some kind of a new age flake, as he called it. He relaxed over the years and well into his therapy, one of my colleagues had put up on the walls of the hallway, between the waiting room and my office, some photographs that were close ups of purple orchids. When I picked him up in the waiting room we walked past those pictures and he didn't even appear to be looking at them. He came in, sat down, and said, "must I talk about those vaginas or can I say whatever I want?" And we both just cracked up laughing, I didn't say to him sternly, "what did you mean by that or what about sexuality." We just thought it was extremely funny. But think about the joke and the levels of things that are going on there. He plays with the Freudian symbol of the flowers as female genitalia. The implication is that I deliberately put up the pictures to force him or coerce him into talking about sexuality which, as everybody knows, Freud thought was at the core of everybody's neurosis. Did he have to comply with that coercive move or was he free to free-associate or talk about whatever he wanted, as he knew he was from the years that we had been working together. I originally wanted to use his joke as the title of the book. So that's one example of how humor in the course of analysis can emerge out of the kind relaxed, friendly relationship that develops. And this wonderful lightness and frivolity leads to a deeper closeness and sense of trust, quite like no other.
Jon:Well, exactly, and we would all have to agree that humor is a very healthy component of the

human experience and we have to also say that humor plays a very large part in creating a situation in the environment of doing psychotherapy that would make a good outcome. But, is there some way that clinical and objective research has shown that psychoanalytic psychotherapy can be effective and can it be clinically proven and how does it compare with say, perhaps, cognitive behavior therapy?

Lou: There are literally hundreds of studies that are being done, in just recent years, that show the effectiveness of psychotherapy. Many many studies show its effectiveness and that it can be profoundly long lasting. There are also studies that show all kinds of other therapies, that have different names, are also effective when they contain the threads and components that I have described: a safe environment, a friendly non-judgmental relationship, active listening, genuine compassion and caring, admitting mistakes and apologizing, in short, being a mensch, a real human being in a relationship of equality.

Jon: Can you tell us when and how do you know that a treatment is drawing to a close, especially given that your case load has included people you saw for many years and often several times a week. Can people afford this today and what are the advantages of such intense and concentrated work?
Lou: There are two parts to that question that I want to talk about. One is seeing people for long periods of time and the other is the issue of money and fees. Let me talk about the second one first. My policy over the years, as far as possible, has been to be flexible with my fees and I've seen a number of people for quite low fees because that's all they could afford. Sometimes for free. For example, if I see somebody for a period of time and they're paying the usual fee, and they lose their job or they're business goes bankrupt, and they have no money, I would continue to see them, even for no fee. Now what was the other part of your question Jon?

Jon: Well it's important to know that as the relationship is drawing to a close that you are able to close them up and summarize and it's also important to determine whether or not people need to be seen several times a week. I'm just wondering what are the advantages of such intense and concentrated work?

Lou: Yes, and how do you know when it's over? I think the big cut-off point, in my experience, is between once and twice a week. I think when you see people once a week, you can only do so much because a whole week goes by and when they come in for their next session a week later they want to just catch you up on what's been happening, their relationships, or whatever their problems are and that takes up the whole next session. Whereas if you see people twice a week, three times a week or more, you do a little bit of that, but then they can get into all kinds of related material, memories, past stuff, if they're having trouble on the job with their boss, they talk about that, and then the next session they might get into exploring how it's just like what used to go on with their father when he was so rigid and authoritarian with them, so you can you expand it and it becomes deeper. Now the question of how do you know when it's over? People typically come into therapy because they have some kind of specific problems: they're anxious, they're phobic, they can't sleep at night, they're depressed, they have low energy, they can't function, they have low self esteem, their relationships are all screwed up, they find that they

keep hooking up with the same abusive man again and again and they don't know why the hell they do that. And those are the kind of things you work on over time and after a period of time, if the therapy is working, the problems have gotten much better and you both know it and, if the gains seem to be lasting, than you can start to talk about well, maybe you've done what you came here to do and we can talk about termination, about ending because something really fine has taken place here. Oh, by the way the term termination, I think, is a terrible one. It comes from Freud and psychoanalysis and it sounds to me like death or when you're getting kicked out, terminated from your job. A bad image, really. I think a better term would be graduation, that you've gone through what you need to do and you're ready now to go on with your life and you don't need to be coming to therapy anymore, so we set a final date, usually give us a couple of months or so to make sure the gains are lasting and wrap up and talk about bringing things to a close. One of the patients, who's called Judith in the book, says herself, when I asked her how did she feel about the end, "I was like a kid going off to college. I felt like I'd done it and I was ready to move on with my life."

Jon: Well you've been active doing therapy and writing books and lecturing for over 40 years, do you think that analysts and therapists like yourself can keep working forever and do they actually get better with experience or is there a tendency to burn out, get bored or become complacent.

Lou: All of the above. I'm officially retired now. I haven't taken any new patients for about 10 years. But I still have some of the people that I've seen for many years that want to stay in touch with me so I have about five or six hours a week of telephone or Skype therapy with these people. And sometimes people you have seen some time ago, something comes up in their life that's terribly upsetting, and they want to come back and talk to you again, so I'm open to doing that with some old patients. But my own feeling has been I really loved being a therapist, liked doing therapy, but like anything else, after 50 years I was ready to retire and not take on any new patients, and sort of wind down with the ones that I had been seeing.

Jon: And so writing books has taken up most of your time in the last 20 years or so and you're going to continue doing that?

Lou: I certainly have spent a lot of time writing in the last years and I felt like I've really gotten pretty good at it and I enjoy doing it and I've written these three books in the last 12 years or so, the two Freud biographies and this new book, the psychotherapy book. And I don't have an idea in my mind for another book right now. The psychotherapy book is a kind of a memoir, a review and wrapping up of my career as a therapist, so it might be my final book, but I have to do something with all of my free time and, if another idea for a book comes to me, why I may write another book. And why not? (laughs heartily.)

Jon: Indeed. So in today's modern world where reading is now becoming passΘ, everything is based on the Internet and modernity and computers, do you think, if you were to consider a future in psychotherapy particularly, psychoanalytic psychotherapy, do you think there always would be a need for it or do you think that some day there will no longer be folks seeking out

help to understand their lives better and improve their personal happiness?

Lou: I'm no better predictor of the future than you are. Two parts to your question, one about books. The publishing business is in a foul state these days and nobody -- I have a lot of friends who are writers and we talk to each other about this -- nobody knows where it's going to go. Are people going to stop reading books all together and just be on their computers or watch television or what have you. But so far, good books still find a place and people do read them or they may read them on Kindle or some electronic format, but they're still books which promote and inflame the personal imagination. What was the other part of your question?

Jon: The future of psychotherapy?

Lou: Ah yes, yes. I think that is going to continue. I think it's been really shown now that, in general, psychodynamic psychotherapy is effective, people need it, they get a lot out of it. People are not going to all of a sudden stop being depressed or anxious or stop having problems in their relationships, and therapy is the most effective thing to do about those kind of life difficulties. So I think it will continue.

Jon:W ell I certainly agree with you but would you also say in addition to that, Lou, that the hallmark statement perhaps about the way that you've done therapy all of your life, really speaks to the phrase, the healing takes place in the relationship. Do you still agree with that?

Lou: That's the central point, Jon, and I absolutely agree with it. Yes, it is the relationship. Someone else said, "the relationship rocks." Or to paraphrase, the slogan from the old Bill Clinton presidential campaign, "it's the relationship, stupid."