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No Pain No Gain? Suffering and the Analysis of Defense

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Abstract: Three attitudes toward psychic pain and suffering are described, and their clinical implications are explored and illustrated. When analyst and patient fundamentally differ in their understanding of the place of suffering in psychic life, potentially treatment destructive clashes can result. The attitude that pain should be reduced as quickly as possible has a significant impact on the analyst's focus in treatment, most especially on the timing of interpretations of defense. A different orientation is the fundamental attitude that pain is an inevitable part of human experience, best accepted rather than avoided. A third possibility embraces suffering as not only unavoidable, but a primary source of wisdom and personal identity.

When I was in graduate school I had a teacher who was much admired, theoretically knowledgeable and intellectually sharp. He could debate anyone, in any analytic lingo. He had high standards, expecting his students and patients to devote much of our resources (financial and otherwise) to a steadfast search for enlightenment. I remember thinking, "This man doesn't understand how hard real life is." I look back, much more aware today that it is possible to love theory *and* appreciate life's hardships. But, in our working methods and public statements, do we fully manifest this appreciation? Do our actions, in sessions, that is, what we highlight and what we ignore, reflect compassionate understanding of just how outnumbered, overwhelmed, unprepared people often feel when faced with serious illnesses, deteriorating parents, financial struggles, clamoring children, maxed out schedules, competing priorities, the difficulties of aging well, among many other everyday challenges? Are we somehow failing to *transmit* our grasp of these issues? Or, like my graduate school teacher, are some of us lost in theories that are intellectually compelling but not sufficiently grounded in life as it is lived?

While we all experience suffering we may not have fully formulated our attitude about its place in psychic life. When is suffering to be borne, rather than medicated, muted, or eradicated? When should it be taken as a sign of a full appreciation of the human condition, rather than a



sign of pathology? Our attitudes about suffering have significant impact on much of our behavior in a session, most especially, on our approach to the analysis of defense. I describe some of the clinical implications of three outlooks toward psychic pain. My main point is that it can be valuable for us to self reflect on our attitudes about suffering, their personal, theoretical, religious, and philosophical origins, and their impact on our clinical approach.

First, let me note that I am using the words "pain," "suffering," "emotional pain," and "psychic pain" interchangeably. I begin with a brief description of the three attitudes and then explore each in greater detail.

1. Primarily, emotional pain is a symptom. Its reduction or elimination is a pivotal aim in treatment. Therefore any method that might delimit suffering, such as medication, should be employed.
2. For the most part, suffering is a human inevitability. An important goal of psychological treatment is to facilitate both participants' efforts to become better able to accept suffering as a part of the human condition, endure it courageously, and with dignity.
3. For centuries suffering has been seen by many as the royal road toward some form of enlightenment, wisdom, or personal identity. Suffering is *the* path toward redemption and self-knowledge. Treatment should further the participants' capacities to learn from their suffering.

Of course all of these attitudes have currency, but I suggest that clinicians differ some in whether we mainly focus on suffering as a symptom, an inevitable burden, or a window of opportunity. What inclines each of us toward our attitude about psychic pain? Perhaps the age of the clinician, and possibly the gender, help shape our often unformulated outlook. Our own life experience seems certain to have an impact. But I think the wider culture and the psychoanalytic culture also play roles in our slant toward suffering.

Should We Aim to Quickly Alleviate Suffering?

I think the attitude that suffering should be alleviated as quickly as possible is much more acceptable in analytic circles than it used to be. In previous eras analysts were more reluctant for patients to take medications to alleviate suffering, partially out of concern that this would reduce their motivation for the psychological treatment that could profoundly and permanently cure. Today, I think it is fair to say that many analysts, as well as non-analytic therapists, and patients, believe that suffering should be alleviated wherever possible, that it is neither noble nor inevitable. Here I want to differentiate attitudes about suffering's cause from attitudes about its cure. A clinician or patient can believe that how we experience our lives causes much of our suffering or see it as more often a product of external forces. Either way the clinician or patient can aim for its rapid alleviation.

The issue of whether pain should be ameliorated as soon as possible has probably most often been raised in relation to medications, but I suggest it comes up in countless other ways. In a recent article about how the clinician might integrate decisions about medication in a psychoanalytic treatment, Glick and Roose (2006, p. 754) explore the differences between psychopharmacologists and analysts in how we are often taught to view the alleviation of suffering.

There is nothing in the training of psychopharmacologists that cautions them to be wary of the wish to cure the patient or of feeling pleasure when it happens. In contrast, the analyst must struggle with a paradox. While the therapeutic aim of analysis is to relieve suffering, in day-to-day practice the analyst is supposed to monitor, examine, and not act on desires to cure.

So, although it seems self evident that simple kindness and compassion require us to try to delimit human suffering (as well, of course, as animal suffering) the analyst may be taught to *first*



monitor rather than act on this wish. We can certainly understand how this could lead to clashes between the analyst and the patient. While not always, it seems obvious that much of the time the patient would want his or her suffering quickly alleviated rather than simply monitored. Feeling *any* kind of pain might, on some level, return human beings to our early days of helplessness. Adam Phillips (1995, p. 33) puts the infant's plight succinctly when he says that "Pain makes us believe that other people have something we need. When we suffer first, as children, we seek people out; and our wish to communicate, and our will to believe in comfort, is urgent."

Thus the analyst, taught to be wary of impulses to alleviate pain, and the patient, wishing to be quickly relieved of pain, are often in an inherently conflict laden situation that inevitably evokes parent-child analogies. We have all been infants, overwhelmed by hunger, thirst, and other inconsistent needs. The power of those who can grant or refuse to grant gratification is absolute.

We know that patients often see clinicians as withholding needed comfort, or relief from suffering, whether or not the clinician feels he or she really has that power. It is interesting to speculate on the part this issue plays in forcing the participants into the traditional transference roles. In any case, I think repeated experiences of clashing with patients who want instant relief may eventually persuade many analysts to adopt a "pain minimizing" stance. Of course some need no prodding to take this position, having entered the field with personal and professional proclivities toward alleviating suffering as quickly as possible. Shortly, I elaborate on how that might play out clinically. But for now, I would like to emphasize the complexity of the forces that can pull even those trained to "monitor" pain, to eventually move closer to a pain minimizing stance. Analytic politics, and even the likelihood of getting referrals, can favor those with a reputation for more quickly relieving suffering. Some analysts feel torn between their training as pain "monitors/explorers" and the benefits of a reputation as a "pain reliever." Also, I think it is easy for conferences to become battles between these two positions. Attendees frequently resort to splitting and devaluation of each other, and idealization of their own position. Those who favor quickly minimizing pain are often told they are not "real" analysts, while those who take a slower approach may be branded with accusations of being holdovers from a more authoritarian age. When it comes to the analyst's attitude toward suffering, infighting can get ugly fast. The political can get insultingly personal, and the personal can unwittingly shape the political.

I suggest that, for each of us, our attitude toward suffering probably correlates with our posture toward intense emotionality in general. Because I have addressed the issue of emotional intensity extensively elsewhere (2004, 2008) I will just mention here that I believe each of us has a rough idea of fitting expressions of sadness, rage, anxiety, and other feelings. However unformulated these notions may be, I think they have tremendous impact on our behavior in sessions. We may not have reflected much on how we arrived at our particular profile of appropriate emotionality. My own belief is that it is generally influenced by our individual character style, as well as our training analyst(s), supervisors, teachers, patients, and personal relationships. For example, life experience, professional training, and personal characteristics have rendered some of us more comfortable than others when we are in the presence of intense rage in ourselves and/or another person. These differences impact our focus on the material in a rage filled session.

The Effect of Attitudes Toward Suffering on the Interpretation of Defense

Regarding the more specific question of how the analyst's attitude toward suffering affects defense interpretation, first I want to emphasize that I believe this discussion pertains to adherents of *all* theoretical schools. For example, I think an analyst who inclines toward minimizing suffering could belong to a classical Freudian, Sullivanian, Jungian, or any other orientation, although I would speculate that personal attitudes about suffering may be one factor in the analyst's original choice of a school of thought. Elsewhere (2004, chapter 9) I have spelled out how I think various currently popular schools of thought fulfill some of an analyst's particular emotional needs. But I am sure that many factors determine which orientation appeals most to each of us.



In what follows I describe several possibilities for how attitudes toward suffering might influence defense interpretation, regardless of the analyst's theoretical allegiances.

How does the assumption that suffering should be minimized as quickly as possible affect defense interpretation? I think it could incline the analyst toward holding off on the interpretation of defense, *regardless* of the analyst's theoretical persuasion. Briefly, I am suggesting that to the degree that an analyst prioritizes minimizing pain, defenses could seem (at least temporarily) like allies. An adherent of this point of view might argue that, since most of us have accepted the notion of dissociation as an aspect of normal functioning we could say the same for denial, repression, splitting, projection, and the other defenses. And, if we believe these defenses are part of healthy functioning, shouldn't we *avoid* (at least, early in treatment) disrupting them? I believe that analysts who are unwilling to consider this issue drive many prospective patients into the arms of practitioners of CBT, where their defenses are given a more cordial welcome. In fact, some non-analytic treatment modes promote, and even teach patients defensive strategies, such as compartmentalization. I am not advocating that we join this throng for the sake of survival as a profession. But I think we should each carefully consider how our (perhaps unexamined) attitudes about pain color our responses to the patient's defenses and our own.

Every moment of every session provides myriad choices about what to focus on. I hear a patient recount an instance of her husband's "emotional generosity." The memory comforts her. I could be silent. I might, by that action, be expressing an inclination to leave well enough alone. But perhaps I believe her vision of his generosity is a defensive distortion. Perhaps I see it as a therapeutic opportunity to further acquaint her with her idealization, splitting, denial, or other aspects of her psychic functioning. Do I value the comfort she is getting from this memory so much that I postpone (for the moment, or indefinitely) closer examination? I don't believe it is enough to say that we just follow the patient's lead in these matters. Some would like to think that we don't have to decide for the patient whether or not to pursue their increasing awareness of defensive processes, since in their associations, in the train of their thought, *they tell us*. While this is true it is not the whole story, to my mind. I think I may have a very different impact if I simply ask how she felt, when her husband was showing his "generosity." Such a seemingly innocuous question might begin an inquiry that results in an altered picture of their interaction. I believe that when the patient tells of her husband's generous action my silence, my seemingly routine question, or any other choices inevitably reflect what I am prioritizing. If I see myself as, primarily, working to minimize pain I will be less likely to focus on a defense that may be helping to preserve the patient's equanimity. I might tell myself (if I am consciously aware of this choice) that it is "too early." But this judgment, too, reflects my priorities.

When I first entered graduate school we learned a basic dictum: with neurotic or healthier patients, analyze defenses so as to make them superfluous. With borderline or more disturbed patients, shore up the defenses. In extreme states of pathology repression is too weak, and the patient may be flooded with terrifying possibilities. Of course this rule over-simplified life in many senses. We are not omniscient, and can't decide who needs what defense, and choose to supply it when necessary. Real people don't neatly fall into categories. Yet, I believe that with every word we utter, or don't utter, in treatment, we are taking a position about consciousness, defenses, and, more generally, emotional wellbeing. But do we know what that is?

I believe that I can not over-estimate the complexity of defining concepts like emotionally "healthy" functioning and "normal" responses to pain. I am not suggesting that I have adequate definitions of them. But I am saying that those of us practicing treatment should consider our point of view about the role of defenses in healthy functioning, and what that should suggest about the goals and techniques of therapy.

If we don't know how to define healthy functioning, how can we know what set of defenses to interpret, trying to undo their limitation on what can be conscious? If we can't be clear about health how do we know that where id is, ego should be? Maybe where id is, id *should remain!*

A textbook geared toward medical students, by authors Carol Donley and Sheryl Buckley,



(2000) asks, in its title, "*What's Normal?*" The introduction (p. 3) suggests that

When the ideal is taken as the norm, variation becomes defined as disease. Too often we convert normal and healthy variabilities into diseases or disorders because they differ from the ideal norm. This reluctance to accept normal variations makes people who are only slightly different from the norm feel unacceptable.

What are some possible clinical applications of these thoughts about normalcy? Are there normal variations in defensive patterns and, if we believe there are, how would that translate into a treatment technique? For a person who relies on repression, is ignorance bliss, or, at least, merely a part of her psychological equipment for living? Should her therapist point out the footprints of repressions in her dreams? Or is it wiser to let those sleeping dogs lie?

I have often thought that the more experienced the clinician, the less eager she is, to interpret everything she thinks she sees, right away. Timing and tact are part of the art of the work. They are hard to teach, but not so difficult to recognize. Are we supporting a defense when we don't interpret what may then remain unconscious? When is that a product of our cowardice, and when is it a product of our wisdom? I think it is impossible to consider these issues without reference to the personal attitude toward suffering that each of us develops, whether or not we ever spell it out.

Should Suffering Be Accepted?

The second attitude I discuss sees suffering as inevitable without, necessarily, seeing it as potentially ennobling. Unlike the first attitude, which unequivocally aims to reduce or eradicate suffering, according to this point of view the recognition and acceptance of suffering is what is crucial. This recognition can alleviate wasted efforts to deny suffering's existence. According to this attitude the central problem is not suffering itself, but the human effort to deny its presence. Freud can be counted among the proponents of this idea. I still get a chill when I read his famously modest claim for the effect of a successful treatment. Speaking to the recipient of such a treatment he predicts that

you will be able to convince yourself that much will be gained if we succeed in transforming your hysterical misery into common unhappiness. With a mental life that has been restored to health you will be better armed against that unhappiness.

(Breuer and Freud, 1895/1957, p. 305)

I can't help thinking of combat. Years of work yields better armor for the endless battles ahead. We help mend the chinks in the armor. This suggests an attitude toward suffering that focuses on its inevitability. The analyst should address *the way people try to avoid pain, rather than the pain itself*. Defensive avoidance of pain can greatly complicate life. I suggest that analysts aiming for the acceptance of pain would be likely to interpret defenses earlier than analysts aiming for pain's eradication or reduction.

Of course, Freud was not alone in this emphasis. Analysts probably generally value facing pain squarely. But at times this attitude can morph into an idealization of stoicism. An extreme example of this, from my point of view, can be found in Richard Taylor's (2002, p. 103) book, *Virtue Ethics*. Describing pride as a virtue that differs from conceit, he illustrates the behavior of the healthily proud person in adversity.

One of the great tests, for example, is the individual's response to acute danger, or his or her reaction to a life-threatening disease or to humiliation at the hands of enemies. One type of person bears these things with a natural, unpracticed fortitude and nobility while, at the other extreme, some collapse into whimpering and self-pity. With respect to death a proud person knows that even his or her own life is not worth clinging to at the cost of pride or honor; would never want it prolonged beyond the point where the virtues upon which pride rests have become debilitated; and would, for this reason, prefer to die ten years too



soon than ten days too late.

And there are other great tests, such as one's reaction to the death of a son or daughter who was intelligent, and strong, and filled with promise of great achievement.

When I try to apply this advice to myself I feel sure that I would fail most of Taylor's tests. Even if a son or daughter of mine was not exceptionally intelligent, strong, or filled with promise, upon their death I would certainly whimper, and plenty more. Taylor's language contrasts nobility, at one end of a spectrum, with whimpering self-pity at the other. What he elevates as healthy pride and fortitude I would see as a kind of schizoid narcissism.

But it is not necessary to idealize suffering in order to believe in making it more conscious. A patient came into treatment years after her mother died. This mother and daughter were extremely close and yet the patient, an intelligent middle aged professional, had never shed a tear about losing her mother. When I asked about this her answer astonished me. In a muted voice she told me she couldn't mourn her mother's death because she hadn't yet taken in that it really happened. This is not a psychotic patient. Yet it seems as though her psyche took the position that mourning this loss would be too much to bear, so she is keeping the full experience at bay. Should I see this as problematic? If I belonged to the first group, the "pain reducers," I might think it best for her defensive equilibrium to stay intact. But if I believe that how we try to avoid pain is a central psychological problem, and a major source of pathology, I might center on making the defensive maneuvers conscious. I would be assuming that the patient will be better off when she can experience, rather than avoid, the pain of mourning.

For historical precedents we can begin with Breuer and Freud's *Studies on Hysteria*, 1895, in which both authors suggest that the failure to remember an event and its associated affect can create conversion symptoms. First, in Breuer's (p. 214) words:

The 'wearing away' influences, however, are all of them effects of association, of thinking, of corrections by reference to other ideas. This process of correction becomes impossible if the affective idea is withdrawn from 'associative contact.' When this happens the idea retains its whole quota of affect.

Later, (p. 255) Freud discusses how conversion symptoms result from ideas torn out of their contexts and away from their accompanying affects. A reversal of this process, however, can restore health:

each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words.

Thus, a disturbing thought or memory must be remembered, so as to be modulated by other cognitive processes, and its associated affect must be abreacted. A fundamental potential conflict between analyst and patient could result from this process. The analyst wants the patient to fully remember and feel, while the patient may want to forget and avoid feelings. Put another way, this premise has the potential to create a clash of wills. The patient's will to defend against memory and emotion will be seen by the analyst as resistance.

This battle of wills follows the analytic couple through the next century and beyond. Sullivan's (1956) "happy idea," and Farber's (1966) "disorders of the will," are labels analysts have used for their patients' willful avoidances. We can see vestiges of this thinking in Abby Stein's (2003, p. 180) poetic descriptions of violated men who become violent criminals. She tells us that she believes that their "perceptions, trace memories, inchoate thoughts and images surrounding abuse instead grow into awesome poltergeists" when they have not been subjected to a healing associative process. In a further description of the course of these unmoored poltergeists, Stein suggests that, "These primitive ideas and affects swirl madly in search of an elaboration that will anchor them somehow to the host's ongoing narrative reality." In other words, torn out of con-



text, torn out of an ongoing, autobiographical narrative, our memories can haunt us. The clinician takes this as a clear directive: help the patient overcome resistances to remembering, and connect the memory with its affects and context, and this truth will then set the patient free.

So, in short, we must overcome the patient's willful avoidance of suffering in order to free him from his unprocessed and disconnected memories. We know that a fundamental difference between Breuer's conception of hysteria and Freud's was that Breuer emphasized the notion that the patient can't remember what occurred in a hypnoid state, whereas for Freud, remembering would engender conflict, and is therefore resisted. Freud put will at the center of a struggle between clinicians and patients; a struggle that has taken various forms, including seductions on the part of either or both participants. In his book, *The Ways of the Will* Leslie Farber (1966, p. 109) had a particularly witty description of the battle:

When this particular absorption with the willful possibilities of sex occurs at the feverish beginnings of psychotherapy, it is apt to be called "positive transference," and to be mistakenly considered a good omen for cure. During this phase, before the two wills begin to oppose each other, the hysteric makes sexuality out of the therapist's science, while the therapist makes science out of sexuality. In this affair, the hysteric has the advantage, there being more sex to science than vice versa.

While analysts these days have broadened the subject matter of what should be remembered, so it is no longer exclusively sexual in nature, I suggest we still generally try to persuade patients that remembering *something* will set them free. For example, Bromberg (1998) emphasizes that Freud's patient, Emmy von M, needed to get all of her selves into the relationship with Freud. According to Bromberg, Emmy had to be helped to overcome the dissociation of some of her self states from the rest. This pattern of dissociation was, originally, defensive. As Bromberg (p. 237) puts it,

...we do not treat patients such as Emmy to cure them of something that was done to them in the past; rather we are trying to cure them of what they still do to themselves and to others in order to *cope* with what was done to them in the past.

As I see it, the conception of the therapeutic action, or the reason *why* we get patients to remember, has shifted, but the battle remains the same. Now it is not simply remembering, and putting the memory back into its affective context, that cures. It is overcoming a willfully defensive dissociation. In effect we make patients a promise. We tell them that bringing all of their self states together will not harm them, but, rather, will set them free. Whereas full self awareness may have been dangerous in the past, it will be curative now. It will spare the energy that has kept self states apart, saving it for more constructive purposes. It will foster the joy of integrity or appreciation of one's wholeness. It will facilitate awareness of life long interpersonal patterns. In our presence, we tell patients, it is safe, and desirable, to remember, once more, with feeling.

It seems worth mentioning again that how we regard emotional intensity, in general, could affect our views about painful memories. Do we think that, ideally, *all* negative emotions (including pain) should be minimized or eliminated? Would human beings be better off with our intense anger excised, along with our intense guilt and other feelings? Who would we then be, and what would be the "side effects" of such a procedure? Without our guilt, how might we behave? This stance negates emotion theory's assumption (Izard, 1977) that *all* the emotions have useful functions, at least potentially. I am underlining the complexity and the many implications of our often unexamined beliefs about human feelings, in general, and human suffering, in particular. For example, I think our attitudes about suffering affect what patients and clinicians are willing to bear, for the sake of the work, as well as the extent of time the treatment can be sustained. Someone who expects all aspects of life and growth to involve pain might be less urgently insistent on a "quick fix."

I remember being told, in my training, that patients often want the outcome of their way of life to improve, without changing the way they live. I think of a patient, a young lawyer, who came into



treatment complaining of tiredness. When I asked her how long her work-day was, she answered "around 15 hours"! When I suggested this would have to change, for her to feel better, she said it couldn't. This is an extreme example, but, at lesser extremes, I don't think it is so uncommon. Patients often *do* want better outcomes without paying the price of changing how they live. And they want them now, not next year. In myself, I think this sometimes elicits a negative reaction. It is as though the patient is demanding a result, but not allowing us the means to accomplish that result. And also, I think, many of us can become judgmental in response to these pressures. We take the attitude that patients are short sighted, greedily wanting dessert without first eating their spinach. We blame the culture for encouraging impulsivity. For example, in a recent publication (Fiscalini, 2009) the clash between the wider culture's values and analytic values has been described as follows.

A new problem, however, looms on the horizon. I refer here to the repudiation of psychoanalytic values by a culture that is impatient, non-reflective, and passively insistent. The complex, much longer, and far more subtle psychoanalysis is abandoned for the seemingly briefer, quicker, less painful, and less expensive, though ultimately less effective, behavior therapies and pop psychologies.

I think I understand the frustration this expresses. Yet I want to make a plea, here, for striking a balance between our investment in the long term reflective process of increasing awareness and the human need to delimit suffering now. Wanting less pain, now, is simply more human than otherwise. If we don't find ways to embrace it, I feel we may consign ourselves to an isolated ivory tower.

Clinical Illustration

In this composite, the patient is a woman in her early 40's. She entered treatment well aware that her childhood was unhappy, but wishing to avoid dwelling on the past. The rhetorical question, what good would it do, often seemed to hang in the air. An only child, still single, her greatest fear is that she will miss out on the joys of partnership and parenthood. With each week her fear increases, as she sees the window of opportunity rapidly closing. But it is too painful to think about. The signals she gives her therapist seem contradictory. Talking about the situation is too painful, but addressing it is absolutely necessary. Changing it is crucial, but thinking about it is impossible, today. Not today. It would be too hard. It would make her feel worse. It is not the right time. The week was too difficult, and she must be calm for tonight's event. She can't function if she gets upset. She is especially shaky and can't take any more, right now. It is too close to one of the holidays that serve as markers of her lonely status. On the other hand, maybe she should have been harsher with her last therapist, who, unconscionably let so much time go by. How could she do that? Didn't she care? Maybe the patient should take medication, so she wouldn't be so anxious about time going by. But would that only allow her to, less uncomfortably, *let it go by*?

The patient enters a session complaining about a colleague at work. Her therapist feels it would be easy to pursue this topic, since the patient brings it in, it is genuinely meaningful, and causes her real frustration. But as the minutes go by, the therapist feels uncomfortable. The biological as well as the chronological clock is ticking. Is the topic of the work problem a defensive diversion from more salient material? If the therapist joins in a discussion of work is she colluding in avoiding more painful, but more essential issues? Is that wrong? Isn't it all related, anyhow? The patient clearly wants to avoid talking about extremely painful subjects. I suggest that her analyst's formulated and unformulated attitudes about suffering are likely to impact her focus in general in the session and, more specifically, the degree to which she focuses on the patient's defenses.

Examples of attitudes about whether suffering should be avoided, reduced, or made more conscious abound in clinical work. They affect many of the moves we make, or don't make, in a



session. They frequently permeate clashes between clinicians and their patients. While it is probable that there are consistent differences between the analytic culture and the wider culture on this score, I can also recognize differences within each culture on attitudes about suffering. No where are these differences more confusing than in relation to depression. Is it to be fully experienced, mined for its potential to make us more whole, more ourselves, and more connected with each other? Is it to be fully felt so defensively running away from it does not permeate the rest of our lives? Or should it be delimited, as much as possible, pharmacologically and psychologically? Depression is probably the type of suffering that most often elicits (in clinicians as well as patients) strong opinions about whether pain should be delimited as quickly as possible, tolerated as well as possible, or mined for what it can teach us. Of course each participant in a treatment might have any attitude, but here I am focusing on the potential clash of an analyst who leans toward accepting or embracing suffering, and a patient who wants to avoid it as much as possible. Stephen Mitchell (1993, p. 209 succinctly summarized this frequent culture clash.

The patient and analyst both surely want something to be different and better; both want the patient to have an experience of living that is richer and fuller. But it is not clear that there is much congruence between the patient's original ideas of what that would entail and the analyst's; rather, as the work proceeds, it generally becomes apparent how different those visions really are.

Embracing Suffering

We are all familiar with versions of the point of view that suffering is the route to salvation. Religious thought, of course, provides many clear illustrations of this idea. Here I can just mention some more contemporary versions, draw a few comparisons between the religious belief in salvation through suffering and some tenets in emotion theory, and suggest some clinical implications of this attitude. Is suffering the royal road toward understanding ourselves and others?

We might begin with the religious vision of attaining salvation by participating in Christ's suffering. In a sense, Christ can be seen as bringing us salvation through our compassion. An analogy can be drawn with Estelle Frankel's (2003, p. 66) "baptism in despair." Her understanding of some Hebrew texts is that pain, and most especially the pain of losing a loved one, can connect us with the infinite, and potentially helps us heal our essential wound of separateness. She sees this as a reason that loss was frequently the gateway to spiritual awakening for ancient mystics. She writes of the thirteenth-century Sufi poet, Rumi, whose teacher Shams disappeared, and may have been murdered. In Frankel's words, "In his grief, however, his heart didn't just break. It broke open, and thereafter his love knew no boundaries." This way of thinking suggests that profound suffering, and most especially the pain of loss, is the condition that most facilitates our development of love, compassion and self-transcendence. Frankel (p. 66) quotes the mystic philosopher, Andrew Harvey, who said, "From the deepest wound of my life grew its miraculous possibility."

Not unrelated is the emotion theory (Izard, 1977) conception of sadness, as having its function in drawing human beings closer together, in a heightened appreciation of our common human condition. Suffering, in other words, is not just something to be courageously and forthrightly endured, but, rather, it is an essential part of us. Potentially it is the great humanizer. Not only are our ties to each other highlighted by suffering, but life itself may be affirmed through it. A few more quotations will have to suffice, to remind us of the many incarnations of this age old idea. In his introduction to the book, *Psychoanalysis and Buddhism: An Unfolding Dialogue*, Jeremy Safran (2003, p. 29) suggests that, "Buddhism places the confrontation with death, loss, and suffering at the heart of things. And ultimately it offers refuge, not in the promise of a better afterlife or protection by a divine figure, but in the form of a pathway toward greater acceptance of life as it is, with all its pain and suffering." He goes on to say that this is what can enhance our ability to truly cherish life.



Another version of what is precious in suffering is that suffering transformed becomes beauty, joy, and art, as well as compassion and self-transcendence. Psychological expressions of this idea abound. For example, the Jungian analyst, James Hollis (1996, p. 67) asks, "Could we even imagine the possibility of joy if we could not contrast it with its opposite? Yet in modern culture we have distorted reality in an addictive search for unalloyed happiness. Such a search can become demonic."

In her compelling book, *The Fasting Girl*, the story of the anorexic, Molly Fancher, Michelle Stacey (2002, pp. 295-6) says:

Is our Prozac-inspired happiness just window-dressing, an easy, mindless glide through life? This is where the question of psychoactive drugs begins to intersect with the divine, with our larger ideas of why we're here on this earth. Religious belief is rooted in struggle: against evil, against meaninglessness, against the uncaring, unethical part of ourselves.

Stacey goes on to describe the Walker Percy novel, *The Thanatos Syndrome*, in which a drug called Heavy Sodium is put into the water supply and removes everyone's angst. The drug is seen as robbing people of their souls.

My favorite poet, Rilke, says (in Baer, 2005, pp. 112-113) succinctly, "What, finally, would be more useless to me than a consoled life?" He advises us, "...to elevate suffering to the level of one's own perspective and to transform it into an aid for one's way of seeing."

I will end this glance at the vast literature on the uses of suffering with words by Bill Moyers, (1991) in an introduction to his book about his conversations with Joseph Campbell, which he titled, *The Power of Myth*. Campbell once said (p. xi) to Moyers, "The secret cause of all suffering ... is mortality itself, which is the prime condition of life. It cannot be denied if life is to be affirmed." Suffering, in other words, has been seen across many cultures, eras, philosophies, and religions as potentially moving us to connect with other human beings, with our own humanity, with sources of personal creativity, with our souls, and with God.

My own version of a clinical application of the idea of suffering as humanizing is that patients can sometimes benefit from seeing me suffer. Of course I don't deliberately set out to suffer. But sessions can sometimes offer opportunities for suffering out loud. Elsewhere (2008) I have called this becoming a "fool for love." That is, especially with patients who bear self-esteem wounds, seeing the analyst struggle, sometimes become overwhelmed, unable to cope, willing to openly feel pain, perhaps to cry, can be very significant therapeutically. Not only might it serve to forge connection and compassion, but it might also negate the patient's sense of being inferior because of his or her suffering. The shame of being unable to think, speak, understand, or remember, can provide occasions for forms of suffering. Simply understanding the patient's suffering can sometimes signal to the patient that I must have known similar pain at some point in my life. In addition, at times of illness or other difficult circumstances, my suffering may become a shared experience. In a recent article (2009) Stuart Pizer wrote of his work with a patient, during a time that Pizer had to have emergency surgery and then a complicated period of convalescence. I discussed his paper (2009) and wrote of a time when my own illness felt different hour by hour, depending, in part, on the patient I happened to be with. Without planning, or, sometimes, without awareness, I believe that I reveal my attitude toward suffering if I try to suppress signs of pain, ill health, or sorrow, as well as when I "wear suffering on my sleeve," so to speak. My experience is that the patient's compassion often plays an unnoticed but significant role in the work, even when I think I'm not showing any suffering. Compassion for my intense effort can also be a factor in treatment. Aside from compassion, sometimes it inspires a greater willingness to meet me half way. In short I wonder how many treatments really take off when the patient begins to identify and feel compassion for a suffering, and/ or undeterred, unashamed, emotionally responsive clinician.



The Attitude That Suffering Humanizes, Ennobles, and Defines

A.C. Bradley (*Shakespearean Tragedy*, 1966) gives us a particularly poetic description of pain as the royal road, in more than one sense of the word "royal." His portrayal of emotional growth through suffering is so evocative that I quote it at length. He says (p. 235) about King Lear that he

comes in his affliction to think of others first, and to seek, in tender solicitude for the poor boy, the shelter he scorns for his own head; who learns to feel and pray for the miserable and houseless poor, to discern the falseness of flattery and the brutality of authority, and to pierce below the differences of rank and raiment to the common humanity beneath; whose sight is so purged by scalding tears that it sees at last how power and place and all things in the world are vanity except love; who tastes in his last hours the extremes both of love's rapture and its agony, but could never, if he lived on or lived again care a jot for aught besides – there is no figure, surely, in the world of poetry at once so grand, so pathetic, and so beautiful as he.

I have already sketched some of the roles suffering has been thought to play in emotional growth. Here I expand on suffering's educative potential, and suggest some ways this attitude might affect the analyst's approach to working with his own and the patient's defenses.

Up until this point I have described how some have seen suffering as the teacher that could best humanize, redeem, even exalt. I think, we can add to the list of its enhancing possibilities its capacity to *define* us, and provide our lives with a sense of *purpose*. Thus some of us think of ourselves as "survivors" (of cancer, rape, war, concentration camps, torture, incest, and other painful experiences). Today, many do insist on language that emphasizes the personhood of the sufferer (e.g. persons with disorders, not "the disordered"). But this still includes the suffering in the person's self-definition.

To my way of thinking there is a curious rift in the wider culture that, perhaps, filters into our own psychoanalytic culture. On the one hand many have a bias toward chemically eliminating suffering wherever possible. Of course the pharmaceutical companies have a stake in persuading us that suffering is unnecessary, avoidable, and totally unproductive. Commercials picture the satisfying life that is possible, if only sufferers have the good sense to pop the right pill. But, on the other hand, our "Oprah" entertainment industry can make suffering into a cultish badge of honor. If I have suffered I am interesting, noteworthy, newsworthy, and, in a sense, special. My suffering may not exalt me spiritually but it helps to define me psychologically, singles me out, and gives me social status. Whereas, at least much of the time, pain used to be a private affair, today we have reality tv, the cell phone, and the paparazzi. Some still prefer a private cry, but many seem intent on exploiting pain to get publicity. Others simply don't seem to care whether casual eavesdroppers can hear their cell phone conversations about their cheating partners or miserably lonely lives. A very funny play, "Jerry Springer: The Opera," made delicious fun of our propensity for putting our pain on display.

This is not new, but I think it is more evident in our information age, with its blogs, Facebook, and other means of instant, wide ranging communication. But there are many precedents. I remember being struck, as a child, with a television program called "Queen For A Day." At least as I recall it, contestants would vie for who had the most miserable sob story. The "winner" got a prize. Tabloids are another example of how human misery can earn serve as a ticket to glamour. Pain is the great equalizer, in a sense. The Hollywood star, the politician, and the ordinary citizen who suffers mightily, and/or who sins dramatically, can achieve fame (and/or infamy).

How does all this affect the analysis of defense? I have already suggested that those who (because of their characters and personal and professional experiences) believe that ignorance can be bliss are the analysts likely to be friendliest toward defense, reluctant to interpret it early, *regardless* of their theoretical orientation (although this attitude about suffering may incline them



toward adopting some orientations more than others). I have also discussed the likelihood that, in contrast, analysts who believe that it is only the truth that can set us free, will interpret defense early. They will see the defense as, *itself*, a central problem, taking up energy that could be better spent and adding dissociative disconnections and hysterical symptoms to the patient's miseries.

But for those who see suffering as the royal road to enlightenment, humanistic wisdom, or personal identity, defenses are *neither* friend nor foe. They are simply not the point. Unlike their colleagues in the first two groups, these analysts are neither loath to interpret defense nor eager. Their focus is elsewhere. They are looking for hurt, not for *what blocks* awareness of pain, but for the *humanizing function of the pain itself*.

Analysts are not alone, in viewing suffering as a potentially great educator and reformer. To close, I would like to quote from two first hand accounts, from people who have each survived periods of intense psychic suffering, and have chosen to write about the subsequent effects on their lives. The first is Lee Springer, who stresses pain's function as a wake-up call.

One grows older and more knowing over time; life's more facile charms grow dim; the soul yearns, seeking more than could ever be had on this earth, more than could ever be wrought out of three dimensions and five senses. We, all of us, suffer some from the limits of living within the flesh. Our walk through this world is never entirely without pain. It lurks in the still, quiet hours which we in our constant busyness, steadfastly avoid. And it has occurred to me since that perhaps what we call depression isn't really a disorder at all but, like physical pain, an alarm of sorts, alerting us that something is undoubtedly wrong, that perhaps it is time to stop, take a time-out, take as long as it takes, and attend to the undressed business of filling our souls.

(Stringer, in Casey, 2001, pp. 112-113.)

Finally, an important point was made by Susanna Keyesen, herself a sufferer from bouts of painful depressive episodes, who wrote an aptly titled essay, "One Cheer for Melancholy" (in Casey, 2001, pp. 38-59). Keyesen highlights how creativity can arise from a will to make sense of one's suffering.

I think melancholy is useful. In its aspect of pensive reflection or contemplation, it's the source of many books (even those complaining about it) and paintings, much scientific insight, the resolution of many fights between couples and friends, and the process known as becoming mature.

To conclude, I have considered how three attitudes about suffering may affect the *timing* of the analyst's interpretations of defense. I suggest that *those who would vote for accepting, rather than either avoiding or embracing suffering, would have the greatest tendency to interpret defensive maneuvers early in treatment*. I want to be clear that I am referring to an attitude that I think affects the timing of defense interpretation. I assume that, on the whole, we would all hope eventually to help our patients integrate much that has been dissociated, for example. But I think we might differ about the timing of when to focus on what we see as the "footprints" of dissociation. Candidates in training so frequently want help developing confidence in their timing. For example, one asks me whether I think that it is too soon to pursue signs of a patient's disturbing early memory. I am suggesting that there is no guide to "technique" isolated from personal, cultural, and professional attitudes about suffering. A general feeling that suffering should be minimized, or accepted, or embraced, will have an impact on how an analyst hears the material in a session. It may even color which psychoanalytic theories she favors, as well as how she understands therapeutic action, psychological health, and the goals of treatment. This is, of course, related to the familiar concept of the impact of the observer on what can be observed.

Analysts are human beings, influenced by countless personal and social pressures. But elsewhere (2004) I have suggested that analysts are also trained in a profession with its own culture. Certain mores, values, hopes, and dreams characterize most analysts, to some degree.



We value truth, sometimes for itself. Most of us are still fans of insight, even though our field has lost its absolute allegiance to it as the vehicle of cure. We are brought up to be troopers. We wouldn't get through our training if we couldn't put something ahead of immediate gratification. And we couldn't get through one day of clinical work if we didn't value something other than ease. On any random day we may participate, with people we have come to care about, in life's most painful trials, in the unanswerable, unbearable, in tragic losses and unimaginable suffering. That makes us unusually familiar with pain's contours. But we are also, therefore, in danger of taking it for granted and, perhaps, forgetting that there are people who may just want help to get through the night. A kind of nonchalance about human suffering could contribute to consigning us to a lonely ivory tower.

In sum, while all analysts have had to learn to tolerate being in the presence of pain, I think we *differ* in our fundamental attitudes about the place of suffering in human psychic life. Those of us who prioritize pain alleviation are not going to focus on clinical material, or on our own countertransference, in the same way as those of us who prize other changes more than the reduction of suffering. I think it is imperative for each of us to examine our own tendencies to treat human suffering, first and foremost, as an obstacle to living fully, or, as an inevitable part of human existence, or, as a vehicle toward the fullest understanding of the human condition and our own, particular, psychic life.

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