CRITIQUE OF TRANSFERENCE

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The analysis of transference is an important tool used by many therapies. Originally formulated by Sigmund Freud, it is central to psychoanalytic practice, and also to many psychodynamic approaches which do not necessarily see themselves as "Freudian." Radical Psychiatrists do not use transference in our practices.[1] Why we have chosen to work as we do illustrates many of the most fundamental theoretical and political differences we have with Freudians.

For many years, we avoided publishing explicit critiques of therapeutic approaches with which we disagreed. Our values oppose competitive behavior (see Chapter 6), and it is very difficult to criticize a point of view that differs from your own without being competitive: "We're right, you're wrong. We know better than you."

But while we've wanted to "set a good example," we've also had a tendency to be provocative. We represent a minority philosophy, and we often see ourselves as David battling a whole lot of Goliaths. Regrettably, we are sometimes rebellious, and express ourselves in challenging absolutes: "The unconscious doesn't exist! There's no such thing as transference!"

I hope to present this chapter in a different spirit. I do believe there are many ways to describe the same phenomenon. We see things one way, while Freudians, as well as many other therapists who do not consider themselves to be Freudians, see them another way. What is interesting is precisely those differences, first why they exist, and second, where they lead in practice. The way we seek to think in Radical Psychiatry opposes concepts of right and wrong, and puts things instead into a context of history and interests (see Chapter 3). It is in that spirit that I hope to conduct this dialogue.

WHY TALK ABOUT FREUD?

Many of our humanist friends tell us they are not interested in debating Freudian ideas, which, they argue, have already been discredited and are old-hat. There was certainly a time, in the decade of the '70s, when that observation seemed to be true.

But times change, and with them philosophies. There is a new interest in Freudian conceptions. Feminists, for instance, were enormously instrumental in opening up dialogue in this area, mounting a very important attack on the obvious misogyny in Freud's writings. Now, however, a cutting edge of feminist psychology seeks to redeem Freud: Nancy Chodorow, Lillian Rubin and Carol Gilligan turn to Object Relations theory to produce a woman-favoring redefinition of the Oedipal transition; Kim Chernin and Susie Ohrbach write brilliantly about the sexist politics of body imagism using a psychoanalytic framework. Local progressive schools of psychotherapy teach "psychodynamic" models which rely heavily on Freudian notions.

This return to Freud does, to be sure, embody important departures from the "master." Freud himself developed a very particular practice, psychoanalysis. Most practitioners today do something else, various forms of psychotherapy that are much less intense than traditional analysis. They see people weekly instead of daily, for five years instead of fifteen. Most psychotherapists allow themselves a good deal more interaction with their clients; few, for instance, have people work "on the couch."

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[1] Other Growth Movement therapies such as Gestalt, Transactional Analysis and Bioenergetics are also uninterested in working with transference.

Yet the concepts of Freud continue to pervade their work. Specifically, three ideas run through much of this more modern work:

1. The unconscious: the idea that certain material is held captive by repression in a part of the psyche which is unavailable to access without some intervention that counters the repressive force.

2. Developmental theory: the idea that a certain order of events universally characterizes the growth of children, and that disturbances (or what JoAnn Costello calls "glitches") in that development decisively affect adult behavior.

3. Diagnosis: the idea that mental experience and behavior can be categorized as healthy or ill, and treated according to a medical model of disease and cure.

Some of these ideas once represented major contributions to the thinking of the times. Freud's articulation of the concept of the unconscious, for example, introduced into the dialogue of his day the necessity to make order out of "irrationality;" on some level, people's imagery and ideas "made sense" to Freud. Liberating notions of sexuality also permeated Freud's work. To a modern mind, many of his ideas seem stilted and obscure. But in his time he was revolutionary in insisting that children and women experience sexuality, and that all sorts of behaviors condemned as "perverse" were in fact natural and, absent of repression, widespread.

WHY CONCENTRATE ON TRANSFERENCE?

In his analytic practice, Freud used three central techniques: free association, dream analysis and transference. The first two of these have fallen relatively out of favor (although there are certainly practitioners who use both). It is transference which continues to be used frequently in psychotherapeutic practice today. Why that is true, I believe, is because the notion of transference most fully embodies the fundamentals of Freud's theory. To analyze this concept, therefore, and to compare it with the work of Radical Psychiatry, is particularly useful both in contrasting the two, and also in illuminating further how we work and why.

In theory, psychoanalysis thinks about the unconscious and developmental theory, while Radical Psychiatry thinks about power and Internalized Oppression.
In practice, psychoanalytic therapists seek to remain unknown as people, to reflect back the experience of their clients, to interpret, and to work one-to-one. Radical Psychiatrists instead use contracts, an analysis of power which seeks to demystify the therapist, and a cooperative contract in a group setting.

These differences, I argue, are *political*. They reflect and carry within them different ideologies, which I want to make explicit in this chapter.

WHAT IS TRANSFERENCE?

It is an important assumption in Radical Psychiatry theory that people are not crazy. However difficult to understand, people's responses are always to something real. Therapists are people, too, including Freud and neo-Freudians. Before defining the Freudian concept of transference, therefore, I want to delineate the real phenomenon to which I believe they are responding.

Freud observed that "patients" often acted toward him with an intensity the cause of which was not immediately obvious. They distrusted him, loved him, hated him, trusted him too much, rebelled against him, and so on. Freud had the hunch that some part of that response was not about him, but reflected instead past experiences and conclusions. His insight is not unique; it is an idea commonly expressed in a number of different forms. Stereotyping, for instance, can be a related phenomenon, in which ideas from other sources determine our responses to what is happening in the moment. Sometimes we generalize from our own experience. Studies have shown, for instance, that patients tell their doctors only what they are asked to tell; they do not volunteer information, because they expect the doctor to ask all the right questions, and to be uninterested in anything they volunteer. Years of experience of exactly that transaction has taught patients a particular expectation, that leads to a particular behavior — what doctors characterize as patients' not giving them all the facts.

Freud focused on the parts of the doctor/patient transaction that were mysterious to him, and he concluded that the mystery lay in the recesses of the patient's past and in her unconscious. He defined transference as "...a whole series of psychological experiences [that] are revived, not as belonging to the past, but as applying to the person of the physician at the present moment." What is more, he interpreted that revival as a distorted one: "The peculiarity of the transference to the physician lies in its excess, in both character and degree, over what is rational and justifiable..."[2]

History of the Idea of Transference

It is a paradox that Freud came to his theoretical conclusions through detailed observation of transactions. A large number of the patients being treated for psychiatric symptoms were "hysterics." Most were women, mostly from the upper classes, who suffered physical ailments that seemed mysterious, unconnected with physical causes, and which consequently were concluded to be " in their heads." Psychoanalysts today report that hysterical symptoms are very rare indeed (although a modern counterpart might be the concept of "psychosomatic" illness); hysteria[3] was very much a phenomenon of the times.

One popular form of treatment was hypnosis. Freud began professional life as a hypnotist. While most hypnotists used simple techniques of suggestion, one, a man named Breuer, had accidentally discovered that hysterical symptoms often vanished if the patient was made, under hypnosis, to recall a traumatic event associated with their onset. Freud became Breuer's student. But where the teacher was content to cure people without insight into the reasons why his technique "worked," Freud was more curious. Indeed, he described himself as a passionate student of society in general, a frustrated anthropologist, forced into medicine to earn a living, but really hungry to discover the origins of all things human. (The search for "the origins" was generally a popular intellectual quest in the last decades of the nineteenth century.)

Freud began to experiment with free association, using it as a research tool to discover more about people's thoughts. He had people lie on a couch (the position commonly assumed by subjects of hypnosis) and say whatever entered their minds, with no censorship. Freud began to notice that at some point, people's associations ran dry; they reported having no further thoughts or images. He was fascinated by the recurrence of that experience, and, interestingly, named it "resistance," seeing it as the first form of transference. Resistance had two meanings for Freud: first, that patients resisted getting well, and second, that they resisted the intervention of the doctor.

To couch these observations in terms of resistance was of some significance. Freud was accustomed to obedience; he was a patriarch in a patriarchal age. His formulation was thus consistent with the social mores of his time. But Freud also had a habit of making great leaps of intuition, and this was one of them.

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[2] "Analysis of a Case of Hysteria," in *Collected Papers*, vol. III, p. 139.

[3] The word *hysteria* is derived from the Greek for "uterus," a broad hint of the gender-based biases connected with the concept.

Many of Freud's ideas about transference and resistance were developed in the course of his working with a particular patient, a woman named Dora. Dora was a young woman who came to Freud because of recurring coughs and respiratory ailments. After three months in analysis, she announced one day that she would consult him no more, and she left furiously angry at him. Freud, predictably, accounted for her behavior as resistance, and in a famous case history analyzed the reasons in her past sexual history that would account for such a transference.

From a modern point of view, Dora had every reason to be enraged at Freud. Dora's father was Freud's friend, and had instigated the "treatment." He was probably genuinely concerned about his daughter's health, but he was also involved in a complex romantic intrigue. His secret lover was the wife of a man who lusted for Dora. The father promoted his daughter's love affair with this man, about whom Dora was profoundly ambivalent. It was in the context of this drama, and the young woman's very smart suspicion that she was being offered up as payment for her father's liaison, that Freud sought to conduct his "scientific" analysis. In the process, he effectively promoted the father's cause. Dora's refusal to cooperate was well justified by the obvious facts of the moment, whatever contribution her past might or might not have made to her decision.

What Freud rightfully discerned was that the transactions of the consulting room could not be disassociated from those of Dora's life, nor of her past. But his interpretation discounted the legitimacy of her rage and lost him his patient.

Modern Usages

The 1980s have witnessed a return to Freudian concepts by many psychotherapists. Such changes of fashion are not arbitrary; they correspond to wider-reaching social trends. In the '60s and '70s, Growth Movement theorists challenged the domain of Freud, because they wanted to replace an intrapsychic view with a more emotional or transactional one. Feminism was one important inspiration for some of these changes by women (and men) angry at the obvious anti-woman bias in Freud's writings (the notion, for instance, of penis envy received pages of bad press). Other therapists, like Eric Berne, wanted to popularize psychological concepts, to make them accessible to people without extensive specialized education. Many practitioners were frustrated with the results of a psychoanalytic method which had become prohibitively lengthy and expensive, and therefore was beyond the reach of any but the most well-to-do and devoted. These were times when hierarchy and professionalism were being challenged on many fronts, when women, for instance, organized to take back power (especially over abortion) from the doctors. To be sure, many of the spokespeople of this therapeutic movement toward the accessible and the obvious did not couch their theory in these terms. Some simply felt ill-suited to the psychoanalytic style:

> I was always terribly bothered by the sense of personal impotence as a therapist doing psychoanalytic work. It always made me feel terribly non-contributory and it always made me feel stifled, insofar as it precluded me from using myself in a way that I felt inclined to use myself, more floridly, and I couldn't stand the rules, of which there were so many spelled out....And I was very depressed by this whole business. I thought that I would open a grocery store rather than go into practice.... *(From an interview with a Behavioral therapist, now migrating toward psychoanalytic psychotherapy.)*

At the same time, both social movements and the turning of numbers of people toward therapy reflected a growing need for meaning and social sustenance. The '60s began a busy trend away from family, toward suburbia and affluence, away from communities. The flower children identified the malaise which resulted, seeking a personal lifestyle revolution. Other movements demanded bettered conditions in other terms.

An active market developed for quick, relatively uncomplicated therapy. Economically, times were good; middle class people could afford to pay reasonable fees for help with their personal quests. The psychiatric system did what American systems are so good at doing — it accommodated the need, making room for "helping" therapies, as opposed to "real, in depth, psychoanalytic cures."

In the '80s, that radical crest has passed. Money is harder won; churches promote old-fashioned virtues; politicians call for a return to the family, and the ethic of hard work and financial stability. Many therapists, like many of their

fellow citizens, fear for their futures, and are no longer willing to be consigned to the radical fringes of society, nor to a deprecated "helping" role.[4]

On the consumers' side, people feel worse about themselves: success is hard to come by, people want "deeper" cures with an intensity that corresponds to the internalization of hard times and intense competition. If you're middle-aged and lose an executive position, or young and unemployed, or female nearing forty, underpaid, at the top of your job ladder, and suddenly scared about being alone, you tend to blame yourself. You, after all, are who the culture blames. If the '70s were a time for realizing potential, the '80s are a time for curing failure. Listen to this modern-day psychoanalyst talking about a patient:

> The chief difficulty is that she simply makes no progress whatever [in her profession]....She's not interested in making progress in her status, she *says*. But it became clear when she came [into analysis] that part of her difficulty was that she wasn't making any and it was eating away at her. *(From a private interview.)*

In recent interviews with therapists, I listened to the ways in which they talked about transference. Their discussions had two very noticeable qualities. First, transference was central to their way of working. Second, they spoke about the concept as if it were beyond dispute, with an unchallengeable absoluteness:

> First of all, defining transference I don't think is that difficult....I know people differ on the uses of it, the abuses of it, how to use the transference, what it means, but I don't think — there's a very small group of people who deny that transference exists. I mean, *I think that's almost like denying that the nose on your face exists*. You can say that your theoretical bent is that you shouldn't use the transference or talk about it. You know, there might be some reasons why you'd want to say that. But to say that it doesn't exist is denying a basic reality of life. *(From a private interview; my italics.)*

In fact, the notion of transference is not so obvious, even to those who use it. Some people use it very specifically to mean that the patient acts out on the therapist her feelings about her parents. This is the simplest definition — a sort of one-to-one mapping of one's unconscious (and "true") relationship with one's father or mother on the person of the therapist. What that relationship is, what parts are important, differ according to the school of thought. Object relationists, for instance, are more concentrated on the very early "diadic" (two-person) relationship with the mother. Freudians look more to the Oedipal period, a three-way drama of mother, father and young child. The therapist I quoted above gave me a more encompassing definition:

> *...transference is all the unconscious feelings, thoughts and assumptions that you bring to a situation based on your past. So it's that microcosm of the past represented in the present that is essentially unconscious because it is timeless*....the feelings we have right now about some situation can re-stimulate earlier experiences and they can go way back to being two months old. It's not a logical choice of `am I going to feel this way?' It just happens. *(From a private conversation; italics added.)*

Transference, Then and Now

Many of the same therapists who saw transference as central to their practices, also told me that Freud is "old-hat." *Their* version, they insisted, was updated, fundamentally changed. It seems to me that there is some truth in that statement. There are some *differences* from Freud's original formulation:

First, there is *less emphasis on disease* — a gain of the Growth Movement period. Many still do diagnose. Kohut, for instance, sees himself as dealing with "narcissistic disorders," but quickly adds that that's just about everyone. While

[4] When I recently interviewed therapists about their work, I discovered that most of them had turned toward more psychoanalytic work than they had done in the previous two decades. Most reported wanting to do "deeper" work.

a disease model certainly still prevails in official psychiatric circles (community agencies, for instance, rely on an elaborate listing of diagnoses called the DMSIII), there is less inclination to diagnose among psychotherapists.

A second, and related, difference is that there is *less emphasis on sexual elements*. In the final analysis, Freud's understanding of neuroses was couched in sexual terms; transference for him, at least in one articulation of the concept, was a process of new symptom formation which encompassed the therapist in a sexuality-laden relationship. Neo-Freudians often see transference in broader terms.

The third difference is that transference is *more likely to be seen transactionally*. Modern neo-Freudian psychotherapists look more at the contribution of the shrink to the patient's responses. Freud thought transference might "cleverly attach itself" to something real about the doctor, but modernists see the doctor as more intrinsically involved.

What has *not* changed since Freud, however, is more fundamental:

Transference still is seen as *resulting from a distortion of early development* (a "developmental glitch") that leads to a disorder of the unconscious.

Secondly, the concept still *represents an attempt to simplify transactions*. The therapist is still trying to be as little a person as possible: some tear labels off magazines that they put in their waiting rooms so patients won't know what they read; others stay strictly out of the public eye, wanting to be invisible:

> ...it would be wrong from a personal standpoint to be identified politically....Because I don't think it's any patient's business. Anything about me.
>
> *Q) Why? What would the harm be?*
>
> (A) It would interfere very seriously with the transference.
>
> *Q) Because? What would they do with that information?*
>
> (A) Because then they'd know who I am. They'd applaud that or they would deplore that. I want to know who they *think* I am. Then I know what's going on with them. (*From a private interview*.)

Thirdly, transference still *represents a very particular power transaction*. As the quote above so clearly states, what is important is what the client brings to the transaction, not the therapist. The doctor knows what is happening, and must interpret it (through words or experience) to the patient. The very concept of transference assumes, first, that the therapist can be a "blank slate" (or very near to it) and, second, that the client has no power to affect the therapist. Learning is all one way; the therapist is static and unchanging, and all dynamic is vested in the "patient."

Transference in Practice

If the job of the therapist is to provide an opportunity for the client to bring her past into the consulting room and lay it bare for understanding, then certain techniques are suggested.

1. Blank Slate: The first, as the analyst above described, is to minimize the effect of the therapist in all transactions. The therapist does not offer advice or opinions, says nothing about herself, decorates his office neutrally, stays out of the public eye, does not put announcements of political events in her waiting room. The therapist is to be a blank slate on which the client, by constructing a certain relationship entirely of her own making, is to write the story of her neuroses.

To be sure, the practice of therapeutic invisibility has come under critical scrutiny by its practitioners in recent years. Psychoanalytic therapists debate whether it is truly a possibility. To be completely neutral, say the critics, is first of all impossible and, secondly, even if it were, is itself a position and an influence. More sophisticated neo-Freudians, therefore, seek a more elaborate understanding of the role the therapist plays in transactions. Nonetheless, the basic goal, to make it possible for the fundamental sense of the transaction to be provided by the client, is unchallenged.

2. Reflection: The therapist does not respond to statements of the client out of her own experience of it, but simply reflects back the sense and/or the emotional tenor of what she has heard: "You feel sad when you think about your father."

3. Interpretation: The therapist seeks explanations for the client's behavior, specifically looking for fulfillment of his theory: "You are mad at me for being cold and unfeeling because your father was cold and paid no attention to you." Psychoanalytic interpretations tend to turn toward the biological family for substance. What is happening in the present is related to childhood family dynamics, especially with the parents. Problems in the world are therefore of interest, not in and of themselves, but as springboards for talking about the past, and about the client's relationship with himself in the present, not with others.

4. One-to-one Therapy: Therapists who rely on transference as a central concept usually prefer to work individually, rather than in groups. While there is an elaborate literature on transference in group therapy, most therapists seek simplicity, and therefore go for the smallest number of people in the room: two. To work with families, couples or groups of people dilutes the transference, because more reality and complexity is introduced.

A RADICAL PSYCHIATRY CRITIQUE

Each of the practices listed above, and the theory on which they are based, carries an ideological, or political, implication. Before analyzing those implications, I list the ways in which Radical Psychiatry practice contrasts.

1. We offer *advice.* This advice is of a particular sort, very closely tied to our values and our theory, specifically about cooperation and power. In the process of giving advice we reveal ourselves, because we make our opinions explicit. We are also implying that clients are powerful enough to sort advice, to reject that which is off and change what is useful in ways that tailor it to their own needs. We are careful about language, never saying, "Do this," but always making clear that what we think is only what we think, not truth.

2. We *validate* people. We look for the material reality in their perceptions first (see Chapter 3). If a client is angry at the therapist, for instance, we look first for our contribution, for the actual events that provoked anger. Our concept of paranoia (see Chapter 8) embodies the idea that what people think and feel is always based on a kernel of truth, on some reality in the world.

3. We take people at their word, in other words, and a specific form of doing so is our use of *contracts* (see Chapter 9). We do not diagnose; we rely instead on the client's own best judgment about what are problems for her. In an example above, the therapist says, "She's not interested in making progress in her status, she *says*," and then goes on to assume that she really was and should be, even though the woman came to work, not on her profession, but on her

marriage. We would take this woman at her word, work on her relationship and trust that she would eventually bring up any problems at work if indeed they were problems for her.

4. We work in *groups*. Our belief in group problem-solving is a very central outcome of our theory. The presence and help of peers is crucial for a number of reasons (see Chapter 9): the most important of them in the context of this discussion about transference is that people can practice working on transactions in the present. In other words, working in groups is a direct reflection of our emphasis on the present rather than the past. To be sure, we do believe the past contributes, indeed that every transaction in the present carries with it a legacy from our past experiences (see Chapter 5). But we believe, first, that the legacy is much larger than what is experienced in the biological family, and second, that it is only important insofar as the present is important. In other words, our emphasis is very heavily on solving problems *now*, rather than on unraveling causes *then*.

All of this is not to say that we think Freudians are “making up” the events on which a theory of transference is based. It is very true that clients sometimes take the word of a therapist very seriously, giving her “too much” power. Sometimes, this transaction may even be tied in some simple and direct way to history with a parent. Often, however, it can be accounted for more satisfactorily by including in the analysis many factors presently at work. The client may, for instance, want real help, and assume the therapist has the power to give it; if she hasn't, why bother to consult her? There is a widespread need for nurturing, support and protection in our culture, for most of us find too little in actual fact.

In addition to real need, the client may also have bought into the mythology about therapists' extraordinary expertise and power. Some people fear the therapist can “see right through me;” in response a client may be scared, or rebellious, or relieved. Often clients with too-high hopes are disappointed; they find the therapist knows some things, but not as much as popular culture predicts, and they may react angrily or sadly — or with relief!

There is another reason why people sometimes turn to therapists with more emotion and intensity than therapists quite fathom. We live in a culture which assigns the guardianship of values, of what is right and wrong, to therapists on a level at which people are most vulnerable — on the level of hearts and minds. The shrink is supposed to be an authority on the “ right” ways to feel and think, and these ideas are values: they are socially determined and consequently ideological.

Some of these expectations may in fact correspond to those originally placed on parents — to nurture, to protect, to understand. But often those expectations are disappointed in the biological family. People come prepared to be disappointed again, hold their hearts and souls in reserve until the therapist proves herself — not a sign of pathology but of good sense. Or else they come with hearts open and hopeful; they “love” the therapist and feel enormous relief in being able to turn for help to someone who supports and understands them — once again a remarkable sign of good “health.”

Radical Psychiatrists analyze transactions between client and therapist, not in terms of illness, but in terms of power. We try to acknowledge real power differences, and to minimize those based on Internalized Oppression, such as lies and misconceptions about therapists and therapy.

The notion of transference says two things very different from such an analysis of power:

1. Most of the explanation has to do with history outside the room.

2. It is precisely that history which is most interesting in therapy.

Why is it most interesting? Because it is assumed that people act out of an *intrapsychic* reality which is unknown to them, fixed in childhood and inaccessible without help from some authority. In other words, the psychoanalytically-

inclined therapist sees the client's response as a distorted one, unrealistic in the circumstances. That opinion is a discount of the client's own perception; what it says is that "the client thinks I have all this power when I really don't." But then the therapist acts in ways that precisely abuse the real power he does have, by having a mystified agenda: to analyze the transactions between the two of them and uncover unconscious developmental glitches. The therapist deeply believes he knows better, possesses a magic key to the psyche of the patient, and that the patient cannot get better without this intervention. If that is true, if clients are dependent on the goodness and smartness of the therapist, then the therapist does indeed possess a great deal of power. In these ways, Freudian therapists claim power, and at the same time disclaim and mystify it.

What are the ideological implications of the theory and practice of transference?

1. Individualism: People are viewed as if they are isolated individuals, each linked in a steely chain with her own individual past. The constancy of change — people changed by life, and life changed by people — is excluded from this view (see Chapter 2). This implication is promoted theoretically by developmental concepts, that the adult is who she has become through the agency of a nuclear family. Practically an ideology of individualism is promoted by one-to-one therapy.

2. Powerlessness: Transference is based on the idea that people cannot sort through and learn from complex transactions, and that they are not capable of doing fifty percent of the work of changing. This implication is contained in the theoretical concept of the unconscious, to which the untreated has no access, and in the practice of concentrating therapeutic attention on the past. What is omitted is real support for taking power in the present, real help learning skills, strategizing, gaining allies and so on.

3. Hierarchy: Therapeutic practice based on transference is inherently hierarchic in structure. To be remote and invisible, yet to direct the very nature and understanding of a relationship, is to be very powerful. The theory out of which hierarchy grows is that of the necessity for intervention by an expert, and the practices which make power unalterably unequal are diagnosis, and the mystification of a therapist who has determined unilaterally what the therapeutic contract is to be.

Freud and the Study of Personal History

Other psychologies are also interested in the past, but with less empowering results. It is in fact our critique of the Freudians that they dwell too intensively in what went before, and not enough in the present. We differ from Freudian approaches in several important respects. First, Freud suggested that the bases of the character were determined in the earliest years of childhood, and could be changed, if at all, only by the detailed recollection and resolution of early conflicts:

> ..we must assume, or we may convince ourselves through psychological observations on others, that the very impressions (of childhood) which we have forgotten have nevertheless left the deepest traces in our psychic life, and acted as determinants for our whole future development.[5]

Radical Psychiatrists, in contrast, believe that we are being formed and reformed all the time, throughout our lives. Every time we transact with another human being, or experience our culture, we are altered. The experiences of childhood are one influence, but they are not "determining." Consequently, we can change ourselves and our lives by changing how we transact right now.

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[5] Freud, *Basic Works*, pp. 581-2.

Second, Freudians view the formative experiences of childhood as occurring primarily within the family. Radical Psychiatrists appreciate the power of our families' ways of treating us in influencing who we become, but we see those ways as being an expression of the social group in which each member of the family and the family as a whole exists. Moreover, we are interested in how those social influences continue to act upon us throughout our lives. Father may treat his small daughter as a pretty doll and introduce the idea that women's power lies in beauty, not brains. But he is only acting in ways he has been trained to act, and every advertisement, every movie, every TV program will promote the notions he has introduced to his daughter throughout her adult life. If the Women's Movement affects him, perhaps because his daughter embraces feminism and confronts him, he may change his behavior and his effect on his daughter, and the consequent changes in her will change him once again.

Thirdly, because Freudian psychologists see people as being hostage to our childhoods, they are interested in present transactions as metaphor for those of the past. Transference, for instance, is the theory that patients act toward their therapists as if the therapist were their parent, and it is the working through of this relationship that enables the patient to resolve inevitable problems with figures of authority. Radical Psychiatrists are interested in how power differences affect relationships between people. We are certainly aware that parent-child relationships are problematic, and so are those between therapists and clients. But we do not presume that they are the same. We seek to do in therapy what children often cannot do with parents, which is to negotiate power inequalities carefully and honestly: I, the therapist, have more power because I'm not working on my life and you, the client, are. So I know more about you than you do about me. But that is an agreed-upon inequality, designed to make it possible for me to protect you while you work, and to give you more useful feedback. If we chose, we could reverse roles; the inequality between us is negotiated and conditional, not built-in.

Sometimes it is true that people act toward a therapist the way they have learned to act toward their parents and others with superior power. We encourage people to work out new ways of confronting power with today's authority figures. Using mother and father as metaphors for authority is largely useless, whatever intellectual appeal it might have; negotiating new relations of equality with actual mothers and fathers relieves contemporary problems and teaches new means of operating in the real world with effective power.