Interview

Nancy McWilliams is a tour de force within contemporary psychoanalysis. Her books *Psychoanalytic Diagnosis* (2nd ed., 2011; first published 1994) and *Psychoanalytic Psychotherapy: A Practitioner's Guide* (2004) are canonical works in psychodynamic and psychoanalytic training across the globe. Her writing is characterized by two main features: on the one hand, a direct, down–to–earth tone that distills complex theories into clear and

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accessible insights. On the other hand, she's well-read in many different psychoanalytic strands (object relations, self psychology, ego psychology, relational psychoanalysis and others) and a master at providing integration of these. As a result, her work is widely read and appreciated both within and beyond psychoanalytic circles. Born in Pennsylvania in 1945, she studied psychology at Rutgers University in the 1960s and 1970s before becoming a psychoanalyst at the National Psychological Association for Psychoanalysis (NPAP) in New York City. She maintains a private practice in Lambertville, New Jersey.

For this interview, we sat down with Nancy the day after the Emotion Revolution conference in Bergen, Norway, in April 2025, where she had just seen Allan Abbass present. In the conversation, Nancy discusses her reactions to seeing his work, to seeing Davanloo tapes in the 1970s and her own relationship to ISTDP. The conversation also explores the relationship between ISTDP and psychoanalytic therapy, teaching psychotherapy and the current state and future of psychotherapy practice and research.

You've been spending the past few days at the Emotion Revolution conference in Bergen, Norway. Do you want to tell me about that? How has it been?

– Wonderful! Usually in conferences they bring me in, I do a speech, maybe I do a workshop, and then I leave. But in this conference, there was a lot of opportunity for learning from others. They had five really distinguished presenters whose work I'm familiar with – except for one, Ann Weiser Cornell's – but I knew Les Greenberg's, Allan Abbass's, and Mark Solms's work. And it was an opportunity to see how they put their ideas into action. Mark Solms was mainly teaching ideas about the neuropsychology of psychotherapy, so he didn't have a video, but everyone else showed videos of their work and talked about their actual work with patients. And I felt I'd died and gone to heaven. I got paid to come here to beautiful Bergen, we had sun the whole time and I got to learn from people who are great teachers. So I got to see what good ISTDP looks like, what good emotion focused therapy looks like. I had a wonderful time, I came here with my husband.[1] We've been enjoying the city – he is also a psychotherapist by the way. He works with psychotic patients. So he was learning a lot, too, from these different approaches. We had a lot to talk about! The food was great. The people were lovely. I was well taken care of. It was a terrific conference.

That sounds wonderful.

– Yeah. There was also a very warm, interested audience that was very responsive. It was a beautifully planned conference – so I would come back in a heartbeat.

It sounds like it's been a great success – I'm sure there will be other iterations of the conference. What was the most interesting moment of the conference?

– I can't isolate one moment, but since your interest is ISTDP – I come to think of one. A very meaningful moment for me was seeing Allan Abbass work with a woman who had a psychogenic disorder, who had a large symptom relief with just a few sessions.[2] And what moved me was his being so moved by her progress – he teared up. I have always associated ISTDP with Davanloo, and the tapes that I've seen of Davanloo were very pounding, getting to the patient's anger. This led me to have, I think, a stereotypical idea about how you always go for the anger [in ISTDP]. And that isn't what I saw in Allan's work. I saw that he was very open to anger, but he often worked with other affects as well. And he felt them himself and could be on the journey with the patient, not just being an expert, telling the patient where to go emotionally. So that was quite a wonder.

I was very struck with how everybody there who was an expert in their particular orientation was very passionate about it and was a very good exemplar of that orientation. But I came away thinking, "I don't think I could do Emotion-focused therapy or Focusing or ISTDP," because... it would be something you'd have to integrate into your personality from an early time in your career, in order to get better and better and better at it. I know they have ways of teaching all these approaches, and perhaps I'm wrong about that, but I thought it was such a privilege to watch Allan Abbass. But I couldn't be Allan Abbass. It would be very difficult for me to work the way he does. Mark Solms said at one point, about Allan, "He never stops talking!" He stays right with the patient. As a psychoanalyst I lean much more in the direction of listening than talking. So it's a big temperamental difference between us.

I remember seeing Allan's work for the first time. I came up to him in the break and I said, "This is great, but I could never do it!". And his response was like, "what you do is you begin taping your sessions and you begin to show them to a supervisor, and then over time your work improves a little bit each week." In ISTDP we have teaching methods designed to help each and every one of us develop more capacity to be present with our patients in this very specific way – but it's a lot of work.

– I think I also thought that – I mean, I knew intellectually this wasn't true because I've read Allan's book about resistance – but I had a stereotype that there was a kind of one size fits all way of interacting to ISTDP. I also thought it was, by definition, a very short-term therapy. But when Allan was talking about working with people who were more fragile, he talked about the need for months or even years of work with some of these patients. So I saw how it has more range.

It's interesting to me. Every form of psychotherapy tends to promote itself initially as a short-term way to help people. And that was true of Freud too. He would talk about having an analysis and he meant six weeks of treatment. And it was true of Carl Rogers, you know, and it was true of the original behaviorists. But now anybody who's a psychoanalyst, a humanistic therapist or CBT therapist with people who need more – they spend a lot of time with them. They appreciate that. So it's kind of an interesting phenomenon that we all start out claiming short-term effectiveness and then have to adapt to the seriousness of some problems that patients have. Not that there aren't short-term versions of all those approaches, but there are also long-term versions of them.

Right now, I think you can talk of the same kind of pattern within the field of psychedelic-assisted therapy. For some people, a short-term course of therapy with psychedelic-assisted sessions would be very effective. But for other people, it's not a short-term treatment.

– Yeah. We all want to help people very quickly. But then we run into the limits of what's possible.

Yeah. Did I understand correctly, that you had seen tapes of Davanloo before?

– Yes, as a graduate student. Now, this would have been in 1970 something. We were exposed to different short-term therapy models: Malan, Mann, Crits-Christoph, Luborsky's work. There were a lot of different short-term models that were being advocated for by various groups. And I saw the videos of "the relentless healer" – this was how Davanloo was described. And I thought, "Well, he can do that, but I couldn't be him." And partly at the time I had a gender reaction to it. I thought that's a very male way of working with people. Going after the defenses. I worked with defenses in a more, what would now be called, attachment way. You make the relationship and gradually, as they feel safe, they'll come to you with their feelings. What I notice is that contemporary ISTDP – and I know the work of Robert Neborsky as well as Allan Abbass – it takes into account the attachment aspects of the work much more explicitly than Davanloo at least spoke about.

I never saw the work of Davanloo myself, so I wouldn't know how to compare it to the ISTDP work I have seen by other teachers. But in the literature and the overall ISTDP discourse I think there's been a focus on highly functioning neurotic patients and the confrontational techniques needed to work with this group of patients.

– Yeah. I remember getting worried at the time that if you tried to do that with more fragile patients, it would be disastrous. The same way, if you're a psychoanalyst and you start interpreting at people who are more fragile. This is a big mistake – they feel persecuted.

For any of these techniques, you don't want people with an exposure in one conference to try to run with it as if they know what they're doing. You know, it's easy to behave like somebody, but if you don't do it with the breadth of real training underneath, you can do serious damage.

Sure. Maybe this is a good moment to think a little bit about overlaps and differences between psychoanalytic therapy and ISTDP?

– Well, I think that ISTDP is a psychoanalytic therapy. From my perspective, I've never defined psychoanalysis as a *type of technique*. I know there are analysts who do. Analysts who have a particularly idealizing attitude toward classical psychoanalysis. And I agree, that that's a wonderful form of psychoanalysis for people who want it and people who are fairly high functioning. It's an extraordinary kind of treatment. And it was deeply valuable for me. But it's not *all* of psychoanalysis. All of psychoanalysis involves a way of thinking about personality dynamics, affect, defenses, how we manage self-esteem, how we come to accept what can't be changed, how we change our inner stories that are so difficult to change, that everybody has their own sort of cognitive, affective story. I think psychoanalysis offers a language that's steeped in clinical experience and increasingly steeped in research. Well, not necessarily. We still aren't very good on randomized controlled trials. But we have a big literature on personality, on attachment, on neuroscience, on development, on defenses. That grounds us in science.

Over these past days at the conference, I felt very much as if Allan and I were in the same family. I've always worked with a range of people, not just the high functioning people. I love doing classical psychoanalysis, but I don't try to fit the patient to the treatment. I try to fit the treatment to the patient. And I think any good psychoanalyst does that. What I learned in this conference was that ISTDP has a language and an approach for doing that as well. When I work with patients that we think of as borderline in the psychoanalytic tradition, I work more like Otto Kernberg than I do when I'm working with somebody on the couch, three or more times a week. And when I'm working with people who struggle with psychosis, I work more like Bertram Karon[3], who was a psychoanalytic person who worked with psychotic patients. Then I'm much more conversational. I might give advice, I might have coffee with the patient, whatever makes them feel safe. So I have never defined the psychoanalytic tradition as a particular approach from which you might deviate for certain patients. It's a body of knowledge and clinical understanding that you apply differently depending on the person – the person's situation, the person's culture, the person's background, the person's expectations and goals for the therapy.

I figure I'm the patient's employee, and they tell me where they want to go, and I tell them if I think I can help them get there and how we'll do it together. And if they sign on, we develop – John Norcross wrote an article about this – a different therapy for every patient.[4] George Silberschatz writes about that too, from the perspective of control mastery theory.[5] And I think all good therapists work like that: with every patient you look a little bit different.

All of that makes a lot of sense to me. Us being part of the same family then, do you think there are things that I could learn from other psychoanalytic approaches and vice versa, things that other psychoanalytic approaches could learn from ISTDP?

– I am a strong believer that we can all learn from everybody. You know, when I wrote a book on supervision recently during Covid – it was my Covid project – I devoted a chapter to talking directly to supervisee's about how to work with supervisors that they didn't necessarily agree with, or they thought that they didn't have compatibility with. You can learn even from people you disagree with. You can find something of value. And if you approach it from the perspective of trying to find something of value for your own work, it's amazing how much you can learn from other people. I have always had a temperament that wanted to integrate things. It's very different from the temperament of more academic colleagues of mine who want to figure out the essential differences between these

things. "Let's run some studies contrasting this with this and see who wins." I do like to be conceptually clear, but I also like to synthesize different approaches. So I'm sure there are things that I can learn from ISTDP. And I'm sure there are things that ISTDP can learn from analysts like me or Mark Solms who are not specifically *doing* ISTDP but also certainly not *anti ISTDP*. It's not like I have to differentiate myself from that.

One thing that I sometimes see as a weakness in ISTDP is the lack of writing about the diagnostic system. When I teach ISTDP I like to use your book *Psychoanalytic Diagnosis*, as a complement to the ISTDP literature on diagnosis. The diagnostic system in ISTDP is very strong, but for beginners it is very hard to master, and your book helps the students understand the background of this line of thinking. When I was in grad school, we studied your book, and it was really a great help in starting to understand patients as a beginning therapist. I really loved that. I imagine that over time people will write about ISTDP diagnosis and hopefully integrate your line of thinking. That's just one thing I think of when I ask this question about learning between different approaches.

– That makes sense to me. Les[lie] Greenberg said something similar to me about emotion focused therapy. We had the interesting situation where I showed a ten minute video of my work with a particular guy, and Les had worked with the same guy because we were both part of an American Psychological Association project contrasting three approaches to therapy.[6]

Les was generous enough to say he thought he could have done better with this guy if he had thought about him from a diagnostic perspective. But EFT doesn't tend to think that way. They don't have a diagnostic overview. And one of the things he felt he learned from the conference was that it might have been valuable to learn how you might approach, how you could get more effectively into the emotional life of a patient if you had some ideas about individual differences. I'm proud that my book has struck a chord with people of a lot of different subtypes of psychoanalysis and even non psychoanalysts. I have CBT colleagues who tell me they like the book because it kind of anchors them in a way of thinking about individual differences. That's very moving to me, because that was what was helpful to me as a beginning student. And so I'm not surprised that you found it helpful and that your students find it helpful.

The book is excellent in bringing all kinds of different theories about psychoanalytic diagnosis together. It's a great bridge to all kinds of different places that you might want to get to after having read it.

– Well, thank you. I'm not that good with Lacan, but most other psychoanalytic orientations I think I understand well enough to integrate.

Maybe integrating Lacan could be a future project?

– You know, I've tried, but his way of thinking diagnostically is almost a different language from the way the more object relations, ego psychology, language that I grew to, to think in. It's hard to think in a different language.

Yeah, definitely. What else comes to your mind as we talk about integrating approaches?

– I was left with a question from watching Allan's work. He stays right with people. He talks, he talks, he talks. He's frequently saying: "How are you feeling with me, right now?" and, "how about your anger toward me, along with your positive feelings toward me?" There's a kind of running commentary that he does. I found myself thinking that there are patients that might feel very impinged on by that. Is that true? Have you noticed differences among patients where some of them want a therapist who holds back more?

If you look at Allan's videos across the spectrum of different patients, I think you will see at times that he can be very quiet and very slow when the patient needs that. When I started studying with Allan I was confused by the frequency of verbal activity, and I didn't understand how much attention he actually puts into his non-verbal sense of what's going on and his observations of what the patient is communicating non-verbally. When is it indicated to do stacked pressure and speak very quickly? Ideally, it's based on being fully attuned.

Sometimes you can do that. Other times it's impossible, and stacked pressure will take you to a bad place. The patient might get up and leave, or the patient might have a strong psychosomatic reaction. So it's really depending on the moment to moment tracking of the patient's process. And it has to be individualized because if you have a resistant patient – a neurotic patient – then there's much more leeway to experiment with that. But if you have a more fragile patient, then, yes, it's easy to have a misalliance if you press someone above their thresholds – they would get anxious, or project, or split, or hallucinate. Does that make sense?

– Yeah, that does make sense. And I did feel that I came away with some strategies for helping people who are suffering with somatic problems. Those are patients that are notoriously difficult for psychoanalysts. I mean, we have some literature about it, and we have knowledge about it. But how to unlock what the body is containing is a struggle for everybody, for all therapists. I have several regular consultation supervision groups where people present their patients. We don't use videos, but we have case presentations and we talk about feelings and conceptualization and so forth. Everybody struggles with those patients, and everybody has their own particular ways of trying to get to the affect behind the symptoms. Trying to make the patient comfortable with the fact that if you're trying to go into their psychological life, it doesn't mean that you're accusing them of malingering. We all struggle with those patients. And I felt like I came out of the conference with some ideas of a style that might help me with a couple of patients that had that kind of problem.

Coming to the theme of research, I think ISTDP has really contributed to the research base overall. There are certain people I'm just deeply grateful to. Peter Fonagy is another one. Patrick Luyten also comes to mind. There are numerous other people who do psychoanalytically oriented research who have saved the psychoanalytic community from the accusation that we have no evidence base for our work. There's now a very, very large evidence base for it.

Right, and Allan Abbass has been a large contributor to that literature. Coming back to what you said about psychosomatic presentations, what are you thinking of when you say you have some new ideas for moving forward? I imagine Allan talked a bit about the ISTDP theory of anxiety discharge. What do you make of that?

– Well, of course, I'd have to really study with an ISTDP supervisor to get good at that. It's not a natural way to think about anxiety for me. I looked at Allan's diagram first, and I didn't even understand the graphic representation of it. But I think I have somehow, just by identification, taken in a style of working that I can use. I'm thinking of a particular man I've been wanting deeply to help. I think he would say that the therapy has been helpful, but he still feels this immense suffering in his body. I think now, just by a kind of identification with having seen it in practice, this is probably why your videotapes are so helpful in training. I could do something like what Allan was doing with him.

I couldn't yet understand the ISTDP diagnostic system, nor teach it. I did try to put some of it into the new edition of the *Psychodynamic Diagnostic Manual* (PDM). I had some correspondence with Allan Abbass who felt that more conversation about it belonged in the PDM. And I studied it enough to understand it, enough to put it in there. But I haven't embodied it yet.

That makes sense. To me, you know, I see ISTDP largely as a kind of oral tradition. It's being passed forward from person to person.

– I think that's how all clinical traditions are really passed on. Although I'm not sure about contemporary CBT. My graduate students in recent years have told me that they were trained that there's an evidence based treatment for this DSM category, and that's what you're supposed to do. And there hasn't been as much attention to integrating it with either their personality or the patient's personality, or understanding the limits of the DSM or anything like that. But in general, I think clinical traditions are about an oral tradition. You know, we find a good supervisor, we find a good teacher, we learn from our own therapist. And we expand to learning from other people. We tend to idealize people and then gradually see where the limitations are and fill in the blanks.

As a clinician my experience has been that most CBT therapists have a lot of respect for the oral traditions of CBT. And that was really quite different from what happened in grad school.

– If you work with people who are really out there trying to help patients, whatever their background, they want to learn from other therapists how they solve certain clinical problems, and they do, and that's how they build their own identity as a therapist.

"Trying to get to the affect behind the symptoms is a struggle for everybody, for all therapists, and we each have our own particular ways of trying to make the patient comfortable as we approach their psychological life."

This brings me back to the theme of using videos. I wonder if there is any particular reason for you not using video or not having adopted that method of teaching and supervising? Or is it just a tradition?

– I'm not sure. I think back to when I started, which would have been in the early 1970s, it wasn't quite so easy to have the technical equipment. I wasn't in a clinical psychology university situation that made it easy to do that. And if you work with a really good supervisor, they can hear in the oral report a lot of the stuff that you're dealing with. So that's just sort of the way I evolved. I'm a private practitioner. It's true that I'm a scholar, but I'm not a full-time person in a research program that has technological facilities to do the kind of videotaping. I suppose, these days you could set it up easily, you could certainly tape zoom sessions. But it just wasn't part of my own socialization into being a therapist.

My husband works with the moment to moment interactions. He has people tape what they do, and then do a transcript. He will then parse out what's happening moment to moment. And I think that's very effective. I'm always reluctant to ask supervisees to transcribe their work. It takes a lot of time. I have taught courses at Rutgers where the students were videoed with their first patient and then showed it to the class, and then we all talked about it. So I'm not completely unfamiliar with working from video. I see the value of it. It's just not as practical in my situation.

Sure. Moving on, I wonder what you think about the future of psychotherapy? In a broader perspective, where do you think psychotherapy will be in 25 or 50 years?

– I hope that we could be more integrative. I hope that the

era of all kinds of competing schools, both within psychoanalysis and between psychoanalysis and other approaches, that we would be starting to see that we have different languages for things, but that we're all working with the same suffering animal. And we all adapt to what is needed in our different languages. I don't know if that will happen because I think as beginners, we tend to want to identify with one approach that orients us. You know that it's too much to train students with the approach of "Well, it all depends", "You have to think of 500 different possibilities here." It's just too overwhelming.

I am involved with a very interesting group now. Marvin Goldfried started this group and he's an eminent cognitive behavioral expert. And Jeanne Watson is in it. She's an EFT person. George Silberschatz is in it. John Norcross, who's an eminent humanistic person. And David Tolan, who is another CBT person, and me and Hanna Levenson. So all the major general schools of psychotherapy are present. We are trying to talk about what we have in common, and especially to be useful to beginning students of psychotherapy, maybe putting up a web page of, you know, different ideas about how you engage with patients and listen to patients and so forth. And we like each other enormously, but we're having a very hard time finding a common language. I mean, we're trying very hard not to use jargon, but what we end up doing, we end up focusing on the most basic and almost trivial things, like how you ask a patient to tell their story.

We started by trying to look at a particular issue, like the patient who is very dependent, very compliant, very afraid of being at all assertive. And how would we all treat that kind of patient? And we tried to compare how we would treat them. The CBT people moved right in on the symptom, while the more analytic and experiential people say, "Wait a minute, you don't even know this patient yet!" And we ended up rethinking and trying to talk about just our different ways of making a relationship with a patient. I don't know where that will go, but that is an effort to synthesize knowledge across different sects. It's interesting how this process is so different from other scientific communities where so much of it feels like religious wars.

Yeah. Why do you think that is?

– I think has to do with our need to feel that we're right. I think it's such a heavy responsibility trying to heal emotional pain that we really want to believe that we have the right language and the right mentors and the right approach. And there is an aspect of psychotherapy where you have to believe in what you're doing. There's a faith element to it. And it is kind of a wisdom tradition. Like all the great religious orientations where we're thinking about meaning and the question of what is the good life? What is in the way of a good life? I don't think it's possible to take it completely out of the realm of faith and identification with faith leaders. And that's probably a healthy tension in some ways – this position between the science and the art.

Then it sounds like – despite the greatest efforts made at synthesizing and integrating – this is a human problem in a way where humans will continue idealizing different leaders and adhering to different schools of thinking or religion.

– I don't see any evidence that we're going to stop doing that as a species!

"What seems to be the most healing is the relationship and whether the therapist is as experienced as they are genuine, interested, empathic, competent, wise, and so forth. That's replicated again and again."

Right. But compared to other strands of medicine, in psychotherapy we're going to continue to be divided in the way we are divided now. Even though of course, things might get integrated in some ways, the way you pose the problem right now it doesn't sound like there's a coming moment of unification.

– Well, fortunately, what we know from research is that the personal connection matters much more than the brand name of the therapy. Therapists need to have an idea of what they're doing, but what seems to be the most healing is the relationship and whether the therapist is as experienced as they are genuine, interested, empathic, competent, wise, and so forth. So that's a finding that's replicated again and again and again and again. I take hope in that.

There's comfort in that. Anyways, I think we're running out of time. Anything else that feels important to say before we come to an end?

– I don't want people to leave the interview with the idea of being pessimistic about the possibility of psychotherapy integration. I think it's a worthy project. I think people will always come up with new ideas, just as they're coming up with psychedelic assisted programs now, and that the tension between the people who hold the tradition, who feel they know what works, and the people who are trying to do something faster, better, deeper, will always be there. And it's not a bad thing.

I agree, it's not a bad thing. Thank you so much for your time!

– It's my pleasure. Thanks.

Footnote

1 Nancy is married to psychotherapist Michael Garrett, known for his groundbreaking work on integrating CBT and psychodynamic therapy for psychosis. For an introduction, see Garrett (2019).

2 Details changed here to protect confidentiality.

3 Bertram P. Karon (1930-2019) was a psychoanalyst who spent a large part of his career developing psychoanalytic treatment for psychosis. One of his seminal works was the book *Psychotherapy of schizophrenia: The treatment of choice* (1977), co-written with Gary R. VandenBos. (Gómez Penedo et al., 2025).

4 Norcross, J. C., & Wampold, B. E. (2018). A new therapy for each patient: Evidence-based relationships and responsiveness. *Journal of clinical psychology, 74*(11), 1889-1906.

5 See i.e. Bugas, J., & Silberschatz, G. (2000). How patients coach their therapists in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 37*(1), 64.

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