Psychoanalytic Quarterly, LXX, 2001

EDITOR'S INTRODUCTION

Some years ago, Wallerstein (1990) proposed that psychoanalysts occupy a common ground consisting of their shared effort to understand clinical events. This Special Issue of *The Psychoanalytic Quarterly* addresses Wallerstein's claim and shows that we must both agree and disagree with it. Yes, there is a common ground, inasmuch as psychoanalysts who in their work with patients pursue essentially the same goals can relatively easily understand one another's efforts, even if they operate with very different theoretical orientations. They can fruitfully compare and contrast their assumptions and conclusions, and constructively debate about their preferred methods.

At the same time, no, there is not a common ground, inasmuch as all psychoanalysts do *not* pursue essentially the same goals in their work with patients. There are decisive differences among psychoanalysts in this regard; and when psychoanalysts pursue different clinical goals, they do not stand on common ground, in any ordinary or useful sense of that term. Many of the most important and long-standing controversies in our field arise and continue unresolved precisely because the antagonists are arguing over the best path to take when they have very different destinations in mind. From each side, intelligent, thoughtful, and conscientious psychoanalysts report shrewd but contrasting observations and inferences; and they disagree about the optimal way to conduct a clinical analysis, because they are working toward entirely different goals. As in the famous rabbi joke, everybody is right. Or, to put it less optimistically, the disputants talk past each other, and can go on doing so indefinitely because they are not discussing the same endeavor.

Perhaps we do not need a consensus concerning the goals of clinical analysis. Our heterogeneity may be, at least for the present, useful to the development of psychoanalytic understanding. If that

is the case, however, it is certainly crucial for us to be quite clear about how we diverge concerning the goals of clinical analysis, when we do diverge. That way, we can eliminate futile controversy, and we can avoid accepting sloppy thinking under the guise of pluralism.

It is with these considerations in mind that *The Psychoanalytic Quarterly* has asked a group of distinguished psychoanalytic authors to articulate their conceptions of the goals of clinical psychoanalysis. We have made sure that a wide range of theoretical perspectives is represented—self psychological, Kleinian, Lacanian, Jungian, traditional Freudian, neo-Freudian, relational, interpersonal, and more—but, as always, "schools of thought" notwithstanding, it is the very particular individual views of the contributors that stimulate us to expand our horizons.

We are extremely pleased with the diverse, provocative group of essays we have been able to assemble. Readers are invited to compare their own impressions with the ones Glen Gabbard offers in his thoughtful "Overview and Commentary." You may agree or disagree. We hope you will do both! In any case, we are confident that you will enjoy and profit from *The Psychoanalytic Quarterly's* Special Issue on "The Goals of Clinical Psychoanalysis."

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Psychoanalytic Quarterly, LXX, 2001

EXPANDING PSYCHOLOGICAL POSSIBILITIES

BY SANDER M. ABEND, M.D.

INTRODUCTION

In my opinion, the essential goal of psychoanalysis can be summed up in a simple phrase: "greater freedom of choice," given the understanding that "choice" means something more than its common-sense implication of making conscious decisions. What is actually implied by the word *choice,* and what analysis hopes to help the patient achieve, is an expanded universe of psychological possibilities, in place of the restricted set he or she was constrained to live with before treatment. In this short essay, I shall strive to explain why I prefer this definition of goals, and I will illustrate how I understand its application with short clinical examples. For the sake of clarity, I shall also mention very briefly the time-honored distinction between analytic goals and life goals, and cast a passing glance at the analyst's goals, as he or she engages in the work of analysis.

I first encountered the conception that analysis seeks to expand the analysand's freedom of choice during my analytic training, and I continue to embrace it, even though I have since come to appreciate that the term *choice* does not refer simply to the realm of conscious, cognitive activities. Greater freedom of choice is meant instead to designate an increased flexibility, a widened spectrum of possible responses to inner and outer stimuli, including, although not limited to, much that transpires outside of deliberate conscious control. I believe that my adherence to this formulation follows logically from my view of what lies at the core of the varieties of human psychological distress that analysis hopes to alleviate. According to my

theoretical beliefs, psychoanalysis attempts to treat the pathogenic consequences of unconscious instinctual conflicts, originating in childhood, and persisting in the form of rigid patterns of emotional and cognitive reactivity that function to restrict a person's affective and behavioral choices and responses.

I fully agree with those who point out that there are crucial shaping and limiting influences attributable to inherent and acquired biological factors, and also to the effects of environmental experience on human development and behavior. However, in my view, these are not the primary foci of concern in psychoanalytic treatment, even though they may have to be taken into account. I agree instead with Kris's (1947) idea that the subject matter of psychoanalysis is "human behavior viewed as conflict" (p. 6). Since I adhere to the traditional Freudian ego psychological understanding of conflict, I conceptualize the outcome of conflict in the theoretical language of unconscious compromise formations. This means that, beginning in childhood, our libidinal and aggressive desires are modulated by a variety of ego functions, operating largely out of conscious awareness, to defend against unpleasure, whether realistic or fantastic in nature. These ego functions also simultaneously serve to make possible as much instinctual gratification as circumstances appear to allow.

Rational and irrational moral constraints, both anticipatory and consequential either to real actions or fantasies, also play a vital role in determining the dynamically complex arrangements we call compromise formations. A more or less stable matrix of compromise formations, in which the aforementioned biological and experiential components are structurally embedded, constitutes each person's psychological makeup. It is inherent in its nature that this network of compromise formations channels the child's, and later the adult's, strivings and reactions into an individually characteristic, limited preferential set of emotional–cognitive–behavioral patterns. Since the determinative developmental history and underlying structural composition of these patterns lie, for the most part, outside the person's conscious understanding, they are significantly, although not totally, resistant to change by life experience and/or by the exer-

cise of conscious will alone. This is largely true of the maladaptive and uncomfortable dysphorias we classify as symptoms, and perhaps even more so of the complex, relatively stable defensive and adaptive arrangements we refer to as character traits.

FREUD'S FORMULATION OF PSYCHOANALYTIC GOALS

Given this set of operative background assumptions, it seems reasonable to hold to an only slightly modified version of Freud's original formulation of psychoanalytic goals. By expanding the analysand's comprehension of the pertinent historical and structural influences that were previously inaccessible to his or her consciousness, analysis seeks to equip the individual to beneficially alter the repertoire of possible choices (whether automatic or deliberately intended) of response, reaction, plan, and/or behavior that are available to deal with inner and outer circumstances. Freud first thought of this as enabling mature, conscious, more or less rational judgment to determine certain actions and reactions, in place of continuing to permit archaic, irrational patterns, originally fixed in place in an immature mental apparatus, to limit the options of the troubled adult.

Experience has taught us that Freud's (1933) aphorism, "where id was, there shall ego be" (p. 80), is both inaccurate and inadequate to describe this goal. I prefer to say instead that analysis enables the formation and use of new compromise formations, which permit the individual to achieve a greater degree of satisfaction in life and a commensurate reduction in unnecessary suffering. We have also come to appreciate that mere intellectual insight into what was previously unknown is often insufficient to produce the desired changes. No analyst today would suggest that the acquisition of insight is all that transpires in a successful analysis, or even that it identifies the sole therapeutic influence of the analytic experience. Nevertheless, increased self-understanding is still regarded as the keystone to the analysand's achievement of greater freedom and flexibility in psychological life.

UNDERSTANDING THE UNCONSCIOUS

My assignment in this paper is not to describe the complexities of therapeutic action, nor even the full dimension of the impact of analysis. Instead, I am to concentrate on the question of goals, by whatever means these are to be reached. Thus, I place emphasis on understanding just how the persistent influence of unconscious mental functioning acts as a limiting, restrictive determinant of human emotional life, thought, and behavior. Psychoanalysis, therefore, seeks to expand the analysand's grasp of his or her unconscious mind and its role in mental reactions and decisions. One consequence will be the person's increased ability to recognize the archaic, less satisfactory patterns, and how they affect his or her life. Even more important, it is hoped that through analysis, better choices will become available, or, stated in terms of my preferred theoretical language, that new compromise formations will emerge, ones that address old dilemmas in a more satisfactory way than was possible before. Thus, the fundamental desires that motivate people psychologically can be dealt with more productively than before, with less unpleasant affect, restriction, self-defeat, or self-punishment, and correspondingly more satisfaction and success, along with their attendant pleasure.

CLINICAL EXAMPLES

Simple, familiar clinical illustrations may help to clarify these ideas. Ms. A, a successful woman in her early thirties, developed a paralyzing fear of flying that threatened her career. This was the symptomatic precipitant that brought her to treatment, although, not surprisingly, she also had other dissatisfactions, chiefly concerning the quality of her romantic attachments. Successful treatment uncovered several layers of the unconscious determinants of her phobia, with progressive relief of her anxiety and the gradual disappearance of this debilitating restriction on her life. It was also helpful in other aspects of her psychological functioning as well. While it can be argued that other kinds of treatment interventions might have re-

lieved her phobic inhibition, in point of fact, this woman was profoundly mistrustful of being influenced in any way, and previous behavioral approaches had consequently not proven helpful in her case. The advantage of the analytic approach was that the sources and nature of her suspicions were also illuminated, and this work aided her in being able to respond more positively to treatment. Not incidentally, her analytic treatment also illuminated other aspects of her conflicts about her career, and clearly helped her to fulfill her considerable ambitions in other ways besides the relief of her fear of flying. She was enabled to pursue her personal goals with less accompanying distress and a much greater degree of conscious satisfaction.

In another situation, Mr. B sought treatment because he was unable to find a satisfactory love relationship with a suitable woman. His analysis revealed that, far from his conscious understanding, many aspects of his character structure contributed to his pattern of making problematic object choices, of which one recurrent feature was their tendency to mercurial mood swings and lack of sustained devotion to him. A lengthy and ultimately successful treatment provided a sufficient increase in his understanding of the determinants of this pattern to eventually increase his flexibility to the point that he could permit himself to find and marry a suitable woman, with whom he built a stable, satisfying marriage. To be sure, his happier choice also reflected the unconscious components of new compromise formations, in addition to his better conscious judgment. Moreover, his increased insight helped him to recognize and break away from his previous proclivities, and materially aided him in the construction of the new solutions to his fundamental conflicts.

In a third, not unusual case, a young man, Mr. C, came to analysis because of recurrent depressions and difficulty in school. His analysis gradually uncovered a powerful set of unconscious submissive, dependent, and essentially masochistic ties to an apparently severely disturbed parent. Over time, this patient was able to achieve a level of independence and self-reliance previously undreamed of by him, along the way choosing a new career path and also gaining considerable relief from his depressive tendencies. Even though one might plausibly posit that other treatment approaches might also

have helped with Mr. C's depressive symptoms, it is difficult to imagine that the satisfaction he gained from his growing sense of independence, and the increase in self-esteem that accompanied it, would have been achieved as easily without the hard-won insight into the nature of his antecedent psychological enslavement provided by the analysis.

In citing these brief examples, I have deliberately refrained from attempting to illustrate specific alterations in the relevant compromise formations. To do so would have required far more detailed clinical descriptions, and in any case, would not have achieved my primary aim. I am aware that there are other useful theoretical dialects besides that of compromise formations that could also be employed to describe the kinds of analytic outcomes I have mentioned. For my present purpose, I wish to place emphasis on the crucial role of unconscious patterning in determining these patients' difficulties, and the analytic focus on effective enlightenment about these patterns, as a means of enabling these patients to construct less restrictive ways to deal with their affects, their desires, and their choices of activities and relationships.

PSYCHOANALYTIC GOALS AND LIFE GOALS

This seems to be the appropriate point to bring up the distinction between psychoanalytic goals and life goals. As important as it was to Ms. A to satisfy her professional ambitions, and for Mr. B to find a wife and have a family, I consider those specific aspirations to lie in the realm of life goals, not analytic ones. Unanticipated, unpredictable internal factors, as well as a host of external variables, including the vagaries of fortune, can affect whether specific, concrete life goals are achieved, or prove instead to be unattainable. This observation is long familiar to psychoanalysts, and the distinction between the two categories has been discussed in the past (Ticho 1972). I think one might say that analytic goals are centered on helping the analysand to acquire better psychological tools and skills

with which to pursue his or her life goals. Whether these new capabilities are employed successfully or not in each case is a question whose answer must include a consideration of the operation of many forces and factors, some of which lie outside the purview of psychoanalytic therapy.

It seems to me that the distinction between the class of concrete, specific life goals, on the one hand, and that of internal psychological capacities that individuals may alter and expand as a result of analytic treatment, on the other hand, is rather easily detailed and understood. However, I believe that an intermediate type of goals also exists, one that may pose a more difficult problem of classification. Consider, for example, the paralyzing anxiety that tormented Ms. A when she was forced to contemplate an airplane trip, or the depressive cast that so troubled Mr. C over a period of several years. These are familiar instances of what analysts, following medical tradition, are accustomed to regard as part of the symptom picture that leads patients to seek relief through therapy in the first place. For Freud, who built on the model provided by his training as a neurologist, there was no question that his psychoanalytic technique was an empirically derived method of treatment of the underlying illnesses, of which neurotic symptoms were only the surface manifestations. Subsequent evolution of the field of psychoanalysis has raised complicated conceptual issues in place of his early certitude.

WHAT PSYCHOANALYSIS CAN ACHIEVE

It would take us much further afield than I wish to go in this essay to address the many intellectual and political influences that have contributed to the blurring of once simple, clear-cut notions of psychoanalytic cure. Suffice it to say that in many psychoanalytic circles today, the very idea of conceiving of psychoanalytic goals in terms of the cure of symptoms is specifically negated. Furthermore, from relatively early on in the history of psychoanalysis, the fact that the underlying unconscious underpinnings of even manifestly painful symptoms often provides important hidden grati-

fication to the individuals who complain of them came to be appreciated as one explanation of patients' resistance to change. Then, too, clinical experience has dictated a deep respect for the often intractable effects of biology, and of traumatic life experiences, on the psychological makeup of many analytic patients. Their troubles may prove to be more or less immutable, despite their own best efforts and those of their analysts. Later in the course of psychoanalytic history, the proposed philosophical shift away from the historical model of disease, treatment, and cure added a further dimension to the vexing problem of defining the goals of analysis.

As far as I am concerned, if an analysis that I conduct does not succeed to any significant degree in relieving the painful distress about which my patient complains when we first agree to work together, I cannot easily reassure myself that a satisfactory analytic outcome has been achieved. Of course, a full assessment of results is often far from simple, since other, unarticulated goals frequently enough emerge as analysis unfolds, and subtle and complex combinations of achievement and disregard, of redefinition and reorganization, of satisfaction and acceptance of limitation, characterize all analytic experiences. That said, I nevertheless always try to keep in mind what patients tell me they suffer from at the start, as well as what other miseries come to light as we work together. The self-comforting reminder that limitations exist which are beyond the power of even the best analysis to overcome is always ready to hand, sometimes even properly so. Nevertheless, this realization rarely succeeds in assuaging my personal sense of disquiet, if my efforts do not help the patient to attain some relief from the troubles that brought him or her to my office in the first place.

The balancing of this view of what I hope my analytic skills can help my patients to achieve, with the recognition that both analysis in general, and this analyst in particular, are far from perfect and far from omnipotent, is one of the burdens of our profession. I suspect that other colleagues struggle to deal with it in much the same fashion that I do. This inner tension also plays an important technical role, expressed in the necessity to monitor my countertransference, while working with my patients on their own evaluations

of their satisfactions and disappointments with the results of our combined endeavors.

Before I pursue further this natural segue into the issue of the analyst's goals, I would like to briefly restate my own view of the aims of the analytic enterprise. I regard psychoanalysis as a form of treatment for various kinds of psychological distress. As such, it is focused on the miseries of which the patient complains, this being understood to include certain kinds of problems uncovered and identified during the course of analysis, which the patient may have been unable to articulate at the outset of therapy. The means by which relief is to be achieved center on an investigation and elaboration of crucial unconscious elements in the patient's makeup that play a role in his or her distress. The procedure, it is hoped, will thereby facilitate the patient's attainment of a new level of flexibility and conscious and unconscious choice in dealing with psychological conflicts. The result, in successful cases, is a reduction in certain dimensions of the patient's emotional suffering, and a consequent increase in the amount of pleasure and satisfaction that can be attained in life, always commensurate with the possibilities realistically open to him or her.

THE PSYCHOANALYST'S GOALS

As to the psychoanalyst's goals, I would emphasize the effort he or she makes to attain and maintain an analytic attitude toward whatever the patient may present. This deceptively simple formula requires some elaboration. The idea that the analyst can function in keeping with Bion's (1967) celebrated advice, "[free from the influence of] memory and desire" (p. 19)—solely as an otherwise unmotivated, sensitive recipient of the patient's immediate conscious and unconscious communications—is, in my opinion, a romantic fiction. So, too, the idea that the analyst is merely interested in understanding and interpreting the unconscious of his or her patients is an anachronistic oversimplification of the task of analyzing.

In a similar vein, it has by now been widely acknowledged that a once-popular opinion—the belief that analytic training, good character, and personal analysis are enough to make of the analyst a uniformly objective, scientific observer of (and thus a neutral interpreter of) the patient's psychology—is naively optimistic. Our current emphasis on the intersubjective nature of the analytic encounter unmistakably illuminates what were long quietly recognized, if at times minimized, sectors of professional disquiet about how analysts, as human beings, actually function.

I do not, however, join those analysts who have seized upon this modern elaboration of the role of the analyst's personality and limitations on his or her work to construct a new prescription for liberalizing former constraints on the analyst's technical stance and practice. It is my opinion that the analytic attitude which I advocate requires of the analyst his or her best possible devotion to the task of reacting to the patient's behavior and communications in a particular fashion. I take this to mean that the analyst attempts, at all times, to understand what is going on in the patient, in him- or herself, and between them, and to translate this understanding, in the analyst's own mind, into the conceptual terminology of our profession. In my case, this terminology is that of conflict and compromise formation, but even if the analyst prefers another theoretical dialect, I hold that the adoption of an analytic attitude entails the same essential elements.

It is by now firmly established that a scrutiny of one's own inner responses, impulses, and behavior is an essential part of the analyst's effort to understand. The acquired understanding is then communicated to each analytic patient in as timely, sensitive, diplomatic, and honest a fashion as the analyst can manage to achieve. Other modes of deliberately attempting to influence the patient besides the transmitting of the kind of understanding I have described, to which the shorthand appellations "interpretation" and "insight" are usually applied, are not part of the ideal analytic attitude.

That the ideal attitude is impossible for the analyst to achieve or sustain, and that in consequence, subtle or sometimes not so subtle means of trying to impact the patient also take place in analysis, is

beyond question. Thus, my view of things is not that the analyst must accomplish the impossible, nor delude him- or herself that it *is* possible. Rather, the analyst's task is to strive to have and sustain an analytic attitude toward patients, and to maintain as much self-awareness about his or her variations from this model—temptations to add something more or to take something away from it—as possible. More cannot be expected, as we have come to realize. Neither, in my opinion at least, should anything less than one's best efforts to approach that standard of excellence be enshrined in analytic technique. I do not agree at all with those who suggest that attempting to adhere to this formula turns the analyst into an uncaring, unempathic surgeon of the psyche, indifferent to outcome or suffering, or unengaged with the patient's life. On the contrary, I think it holds the promise of maximizing the patient's prospects for defining and finding his or her own best potential. This, to be sure, is no insignificant goal, and obviously one well worth the challenge it imposes on analyst and analysand alike.

CONCLUSION

In summary, then, one can restate the goals of psychoanalysis in the following way: Patients seek relief from certain miseries and dissatisfaction, as well as the successful pursuit of greater fulfillment in life. Analysis hopes to help them in these aims by illuminating the nature of those unconscious mental activities that contribute to their troubles and interfere with their satisfactions. It is hoped that sufficient new understanding of the history and nature of those unconscious dimensions of their psychological functioning will enable analysands to achieve an increased level of flexibility and a greater range of choice, deliberate or otherwise, of thought, emotions, and behavior. This expansion of psychological possibilities, in turn, can help them to attain their more proximate goals of decreasing unnecessary pain and of finding greater pleasure. The analyst, in exercising his or her skills in the service of the patient's quest, tries to aid in the gradual expansion of the pa-

tient's useful self-knowledge. He or she does so, insofar as possible, without otherwise attempting to dictate or to persuade the patient to live life according to any precepts other than those valued independently by the patient.

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Psychoanalytic Quarterly, LXX, 2001

LIFE GOALS AND PSYCHOANALYTIC GOALS FROM A HISTORICAL PERSPECTIVE

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In ordinary medicine, the goal of treatment is to undo the deleterious effect of the disease, to bring back the status quo before the disease disturbs the equilibrium. In traumatic neurosis, a similar aim can at times be pursued, but even there, if psychoanalysis has not failed, something new that was never there before will emerge. Whatever the aims of psychoanalysis may be, and they have changed significantly during its history, they were never to bring back what once existed. This is so even if psychoanalysts say that they are aiming at giving back to their patients the mental health they lost at a certain stage in their development.

Because psychoanalysis aims at more than restoration, the issue of its goals is both interesting and controversial. In the present climate of opinion, psychoanalysis is pressed to demonstrate its cost effectiveness against other therapies. The outcome of that controversy is still in doubt, but what remains certain is that if the value of "know thyself," first articulated in the city of Delphi in Ancient Greece, is still important, psychoanalysis has no rival among other forms of psychotherapy.

THE FIRST PHASE

When Freud exchanged the hypnotic method for free associations around the turn of the century, he moved from the highly authori-

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A German-language version of this paper was read at the annual convention of M. A. P. in Munich on November 12, 1999.

tarian stance of a hypnotist who gives orders to a hypnotized patient, to that of a therapist who must listen carefully to the associations of an analysand and do his or her best to make sense of them, in order to make an interpretation. Freud expressed the difference between the analyst and the hypnotist in a beautiful metaphor taken from Leonardo da Vinci. Leonardo wrote that a painter adds substance to the canvas in the form of paint, whereas the sculptor works by removing blocks of stone from the statue that he is freeing from imprisonment within the stone. As he put it, the painter works *via di porre*, while the sculptor works *via di levare* (Freud 1905, p. 260). The psychoanalyst shall take the sculptor as his or her ideal.

In 1914, Freud noted that this very significant step was not the result of a deliberate process of thought, but rather of following a "dim presentiment" (1914a, p. 19). Logical thinking (secondary process) is by its very nature goal directed, and whatever stands in the way of its aim must be eliminated by the thinker. When we try to think logically, we have to continuously repress thoughts and feelings not pertinent to the task at hand. By contrast, during free associations, the patient undergoing psychoanalysis is under obligation to say whatever occurs to him or her and to refrain from censorship. Usually, the most important task is to make sure that nothing is being censored. If the analyst can, in addition, make sense of such free associations, it is due to the fact that even the freest of associations are psychically determined. Freud's goal of making the unconscious conscious rested on a basic belief that the fragile ego of the child has no choice but to repress, while the adult undergoing psychoanalysis can tolerate the derivatives of what has had to be repressed, ultimately confronting the unconscious in a way the child could not. This optimism, which Freud inherited from the era of Enlightenment, did not always prove to be true. Many adults repress as much as children do.

According to Freud, the analyst should follow these free associations while in a state similar to that of the patient. In 1912, he put it thus:

> The technique, however, is a very simple one. As we shall see, it rejects the use of any special expedient (even that of

> taking notes). It consists simply in not directing one's notice to anything in particular and in maintaining the same "evenly-suspended attention" (as I have called it) in the face of all that one hears. In this way we spare ourselves a strain on our attention which could not in any case be kept up for several hours daily, and we avoid a danger which is inseparable from the exercise of deliberate attention. [pp. 111-112]

If both analyst and analysand try to follow their respective roles, the analytic process will be set into motion. Freud noted that when his patients tried to remember their childhoods, gaps appeared in their memories, chronology became confused, and causal connections were broken. The free association lost coherence. When that happened, Freud understood that resistance to the analytic process had set in. Once childhood amnesia was overcome, symptoms tended to lose their grip on the patient.

Freud believed that during analysis, the increased understanding of oneself goes hand in hand with the process of cure. He continuously warned his disciples against *furor senandi*, the excessive zeal to cure. What psychoanalysis should aim for is not so much to cure as to enable the analysand to obtain a conscious grasp of unconscious wishes. Seen in a historical context, the attainment of this goal represented a major triumph for the rationality of the Enlightenment. Freud could claim that he had found a method to subjugate the inner life of man to the scientific demands of natural science. As Fenichel would later put it in 1945, there are many ways of curing psychoneurosis, but only one way to understand it, and that was Freud's way. In the same spirit, Freud published his papers on technique (1912). He carefully called them "recommendations," not instructions; however, in time, the movement's orthodoxy transformed them into just such instructions.

Among Freud's disciples, those who knew him face to face, only Reik reacted with enthusiasm to the technique in which both analyst and analysand relinquish all aims except to let their unconscious minds speak. In a book published only in German, *Der Überraschte Psychologe* (1935), Reik suggested that, as the analyst listens to his or her patient, a complex process is set in motion, whereby the analyst

moves from guessing (*erraten*) to understanding (*verstehen*). However, this technique, Reik believed, cannot be taught (*nicht erlernbar*), but can only be experienced (*erlebbar*). After his immigration to the United States, Reik was not accepted as a member of the American Psychoanalytic Association, and his ideas were no longer included in the official psychoanalytic curriculum. Identifying himself with a younger Freud during "his splendid isolation" (Freud 1914a, p. 22), Reik began to publish a series of books addressed to the general reader, and gradually assembled his own group of disciples; he was a very popular writer for a time. In 1948, *Listening with the Third Ear*, subtitled *The Inner Experience of the Analyst*, appeared. This book was followed in 1949 by *Fragment of a Great Confession*, subtitled *A Psychoanalytic Autobiography*.

In 1967, Bion made recommendations about the analyst's attitude which were similar to Freud's, when he wrote:

> Psychoanalytic observation is concerned neither with what has happened nor with what is going to happen, but rather with what is happening . . . .
>
> Every session attended by the psychoanalyst must have no history and no future . . . .
>
> Do not remember past sessions. The greater the impulse to remember what has been said or done, the more the need to resist it. [p. 272]

Fenichel, in his 1941 book on technique, warned of two dangers at opposite ends of a spectrum:

> There are doubtless some analysts who would like to substitute knowledge for experiences and who therefore do not dissolve repressions but rather play thinking games with their patients. There are perhaps at least as many analysts who commit another equally serious error. They misuse the idea of the analyst's unconscious as the instrument of his perception so that they do hardly any work at all in analysis but just "float" in it, sit and merely "experience" things in

> such a way as to understand fragments of the unconscious processes of the patient and unselectively communicate them to him. [p. 5]

> Psychoanalytic technique is a complicated task. Its tool is the unconscious of the analyst which intuitively comprehends the unconscious of the patient. Its aim is to lift this comprehension out of intuition into scientific clarity. [p. 12]

Although few psychoanalysts today draw their inspiration from Freud's concept of free-floating attention, it is Green's (1999) belief that the 1912 concept has not lost its vitality.

> I place myself in the analyst's position, when, having forced myself to maintain as much as possible freely floating attention—as we shall see, this is no easy matter and sometimes encounters serious difficulties—I hear the analysand's communication from two points of view at once. That is to say, on the one hand, I try to perceive the internal conflicts that inhabit it and, on the other, I consider it from the point of view of something addressed, implicitly or explicitly, to me. [p. 278]

THE SECOND PHASE

In his 1914(b) paper on technique, Freud introduced new goals. These included analyzing screen memories to extract from them what had really happened. These screen memories were equivalent to the manifest content of dreams, and could be made to reveal previously hidden latent content (p. 148). The next task was to transform what the analytic patient tended to act out in memories. Freud realized that a neurotic illness is not something that happened in the past, but rather is "a present day force" (p. 151). Freud believed that the most important technical tool he had originated was the intensification of the transference, such that the analysand's neurosis is transformed into a transference neurosis, in which every important aspect of the patient's past is relived in the relationship to the analyst.

Freud's emphasis on making the unconscious conscious was consistent with his early topographical point of view, which could easily incorporate his idea that the analyst should pursue no specific goals. In contrast, the structural point of view, introduced in 1923, in which Freud divided the psychic apparatus into superego, ego, and id, created new aims for psychoanalysis beyond the early idea of making the unconscious conscious. In the 1923 formulation, only when the ego is strong enough to hold in check both id and superego does a person approach normality and mental health. In delinquency and perversion, the id overrules the ego, and in depression and melancholia, it is the superego that has acquired dominance. Within this structural point of view, the aim of psychoanalysis became the strengthening of the ego against the other two institutions, and also helping the ego free itself from the power of some of its own defense mechanisms, acquired during childhood, which can cripple the ego's freedom of movement. The aim of psychoanalysis became the achievement of a more favorable kind of intrapsychic compromise formation.

During the teens of the twentieth century, Freud's voice alone determined the course psychoanalysis would take, but beginning with the 1920s, other voices, not always in agreement with his, began to influence the development of psychoanalysis. In 1924, Ferenczi and Rank jointly published a book, which—at least in the original German edition—had the word *goals* in its very title, *Entwicklungsziele der Psychoanalyse.* (The English translation, published in 1925, was entitled *The Development of Psychoanalysis.)* In the view of these authors, the psychoanalytic situation exposes the patient to early infantile traumatic situations. A parental imago is offered with whom the patient can relive early libidinal emotions and early traumatic experiences. Many patients feel cured when they have happily fallen in love with their analysts; but the analyst cannot stop at such a point, for analysis aims at weaning the analysand through insight; the analysand must understand that reawakened infantile wishes are contradicted by current reality and the adult's ego ideal.

Both Ferenczi and Rank published other books independently at about the same time. Rank, in *The Trauma of Birth* (1924), made the

abreaction to the "birth trauma" the final aim of psychoanalytic psychotherapy. Ferenczi, in a book entitled *Thalassa: A Theory of Genitality* (1924), accepted the idea that the return to the womb is the analysand's constant unconscious goal, but added that the analysand wishes to reach this goal through "passive object love." When the analysand discovers that passivity toward the analyst does not bring about the desired fulfillment, a second "autoplastic masturbatory" phase sets in, in which the analysand attempts to turn away from any dependency on the analyst. This second phase also has to be worked through. Only at the end of the analysis is an active capacity to search and find a new love object sufficiently strong to bring about the termination of the analysis.

A central point—the wish to return to the womb—characterized both books, and probably explains why Ferenczi and Rank, in spite of marked differences in thinking, could embark upon writing a joint book. Ferenczi's 1927 paper on termination, the first ever to address this stage, was written entirely within an emphasis on the absence of goals.

> The proper ending of an analysis is when neither the physician nor the patient puts an end to it, but when it dies of exhaustion, so to speak, though even when this occurs the physician must be the more suspicious of the two and must think of the possibility that behind the patient's wish to take his departure some neurotic factor may still be concealed. A truly cured patient frees himself from analysis slowly but surely; so long as he wishes to come to analysis, he should continue to do so. [p. 85]

Even in this paper, however, Ferenczi introduced many goals that an analyst should have in mind. Not satisfied with symptom analysis, he believed that no analysis can be ended without a complete character analysis (p. 80). He insisted that every male patient attain feelings of equality in relation to the analyst, and every female patient must get rid of her "masculine complex" without a trace of resentment (p. 84).

In 1935, Balint, Ferenczi's best-known disciple, published a paper entitled "The Final Goals of Psychoanalysis," in which the author

maintained that an effective analyst should enable the analysand to gain the capacity for a "new beginning" (p. 192). In Balint's view, the libido was always object-seeking rather than pleasure-seeking. The self-erotic and narcissistic strivings from which so many men and women suffer are the results of disappointments in early object relationships—primarily the relationship to the mother. The goal of analysis is to work through these early disappointments, so that upon its completion, a capacity to love without inner inhibitions has been newly acquired. A new emphasis on trauma is discernible in Balint's views. In variations, the same idea is found in the writings of Loewald (1960) and Winnicott (1971). Winnicott emphasized particularly the renewal of the lost capacity to play, and Loewald the capacity to experience the analyst as a new object.

I contributed to this discussion (Bergmann 1986) when it became clear to me that an analytic patient who develops a strong transference love toward the analyst is not necessarily capable of loving in real life. The fact that the analyst makes no demand to be loved by the patient, and accepts and tolerates aggression within the transference, can evoke love in the analysand that remains untransferable into real life.

The model advocated by Freud in 1912, which both Reik and Bion endorsed, was too individual and too anarchic to be useful to budding psychoanalytic institutions. When in 1922, Karl Abraham and Max Eidingon created the first psychoanalytic institute for the training of future analysts, they did so according to a tripartite model, which stipulated a personal analysis, a specified number of cases that had to be supervised by a training analyst, and systematic, psychoanalytic course work. In practice, the supervising analyst could hardly be expected to act as a midwife to the younger analyst's creativity while still allowing him or her to develop an individualized way of listening and interpreting. The training analyst typically told the analyst in training how he or she, the training analyst, would have interpreted the material. Thus, the method Freud originally advocated could not be learned, in part because it could not be taught.

There was another danger inherent in this model: it was too easy for the analyst to project his or her own ideas, wishes, and fears onto

the patient. To prevent such an inappropriate "countertransference," it became mandatory for every analyst to undergo a training analysis, which removed some of these dangers. However, the analysis of the analyst could hardly be expected to go deep enough to eliminate all personal bias, and furthermore, every institute of necessity developed its own interpretation of Freud's work, fostering uniformity rather than creativity in beginning analysts within that institute.

THE THIRD PHASE

After World War II, a new interest in the aims of psychoanalysis emerged, at least in the United States. This attraction to the field did not arise out of intrinsic interest in the analytic process, but more as a result of new cultural forces that had to be dealt with. Before World War II, psychoanalysis had essentially been a private practice enterprise, but after the war, once the influence of analysis on several disciplines—psychiatry, psychology, and social work, for example—had led to remarkable progress, the American Psychoanalytic Association made every effort to continue to act as an influential force within these professions. It succeeded in dominating academic psychiatry, but this very success forced American psychoanalysts to reconsider the relationship between psychoanalysis and psychotherapy. Psychiatric residents could not be expected to become analysts, but they had to learn how to apply the principles of psychoanalysis in psychotherapy.

The hitherto prevalent opinion within psychoanalysis toward psychotherapy was expressed by Freud via a metaphor comparing psychoanalytic gold with psychotherapeutic copper. This metaphor gave psychotherapists who were influenced by analysis a feeling of inferiority, and therefore did not adequately serve the needs of psychoanalytically oriented psychotherapists. The more successful the discipline of psychoanalysis became in its conquest, the more urgent it was to define the demarcation lines between the two modalities. The best-known paper dealing with this problem was Eissler's, entitled "The Effect of the Structure of the Ego on Psychoanalytic

Technique" (1953), the so-called parameter paper. It included the following comment:

> If our knowledge of the structure of the ego were complete, then a variety of techniques—ideally adapted to the requirements of the individual disturbance—could be perfected; thus we could assure definite mastery of the ego over those areas in which it had suffered defeat, that is to say, assure complete recovery. [p. 104]

A year later, the *Journal of the American Psychoanalytic Association* published a number of papers on the relationship between psychoanalysis and psychotherapy. In these discussions, the issue of the goals of psychoanalysis played a major role. A new sense of victory was discernible in Alexander's (1954) paper:

> Psychiatrists came to recognize more and more the fundamental nature of Freud's discoveries, and psychiatric practice both officially and unofficially became highly influenced by psychoanalysis. Many psychoanalysts felt that through this change in the cultural climate our role and responsibility have changed. Now, when psychiatry is not only ready but eager to assimilate in an undiluted form the teachings of Freud and the work of his followers, we felt that it became our responsibility to guide and facilitate this process of incorporation. [p. 724]

Alexander singled out for attack what he called the "regressive-dependent component of the transference" (p. 732), the very regression that Balint, Winnicott, and other psychoanalysts considered a prerequisite for "a new beginning" (Balint 1935, p. 192). To prevent a regression from taking place, Alexander recommended that the frequency of analytic hours be changed when the analysand became too dependent. In fact, Alexander and his colleagues advocated the dissolution of analysis as a separate profession and favored its merging into psychiatry. The question of how much regression on the part of the patient the analyst should foster, or even allow, became a controversial topic with respect to the goals of analysis.

Rangell (1954) noted that dynamic psychiatrists view childhood in terms of interpersonal relationships, rather than in terms of psychosexual development. As a compromise, in opposition to Alexander's viewpoint, Rangell proposed the following definition of psychoanalysis:

> Psychoanalysis is a method of therapy *whereby* conditions are brought about favorable for the development of a transference neurosis, in which the past is restored in the present, *in order that*, through a systematic interpretative attack on the resistances which oppose it, there occurs a resolution of that neurosis (transference *and* infantile) *to the end* of bringing about structural changes in the mental apparatus of the patient to make the latter capable of optimum adaptation to life. [pp. 739-740, italics in original]

Gill (1954) offered an almost identical definition:

> Psychoanalysis is that technique which, employed by a neutral analyst, results in the development of a regressive transference neurosis and the ultimate resolution of this neurosis by techniques of interpretation alone. [p. 775]

In the long run, identification of transference neurosis as differentiating psychoanalysis from psychotherapy proved to be a concept that was impossible to maintain. Many analysands did not develop a transference neurosis and many patients in psychotherapy did.

Stone, in his by now famous paper on "the widening scope of psychoanalysis" (1954), raised the question of how much the classical analytic method can be modified and still be regarded as analysis (p. 575). He accepted Eissler's ideas of the need for parameters, but objected to the fact that all parameters must terminate and be interpreted before the end of analysis (p. 576). Stone's paper signaled permission to extend psychoanalysis beyond the limits of the neuroses.

In 1965, Wallerstein called for a distinction between "idealized goals" and "attainable goals." He noted that no person can be com-

pletely analyzed or attain perfect mental health. The psychoanalytic process may therefore be goalless, but its implicit goal is a radical change in character realignment.

Ticho (1972) called for a distinction between treatment goals and life goals. Life goals are those that an analysand would seek to obtain if he or she could put his or her potentialities to full use. Life goals were further divided by Ticho into professional and personal ones, with personal goals involving the kind of person the patient would like to become. The analysis itself should not be permitted to become a life goal. Treatment goals, on the other hand, aim to help the patient understand his or her neurosis, which in turn should enable the patient to differentiate between his or her conscious goals and unconscious ones. This insight, the distinction between treatment goals and life goals, makes it possible for the analysand to achieve "unified treatment goals" (p. 315).

The distinction between life goals and treatment goals becomes crucial when a life goal of the analysand turns out to be beyond the reach of the treatment—for example, when a life partner cannot be found, or when a phobia cannot be overcome. Should the analyst continue to analyze with the hope that the life goal will become reachable? Or should we aim only at treatment goals, such as self-knowledge, giving the patient access to his or her unconscious through free associations and the interpretation of dreams? There is a tendency in the analytic literature to obscure this line of demarcation between types of goals.

When Ticho published the above-mentioned paper, the prestige of analysis within psychiatry was high, and it was also esteemed by the general public. But when analysis began to come under attack, the need to concentrate on life goals became urgent in order to show that analysis is cost effective in comparison with other treatment procedures (Bader 1994). For many years, Freud's decision to bring the treatment of the Wolf Man to an end had been regarded as a technical error, but in the new climate, it was commended (Gunderson and Gabbard 1999, p. 692).

Weinshel (1990) described particularly well the changes that had taken place in the mainstream of American psychoanalysis, ob-

serving that there had been a shift toward greater modesty in the pursuit of analytic goals. His main points (pp. 281-283) might be briefly summarized as follows:

1. We rarely speak any more of psychoanalytic "cures." We are much more likely to focus on changes, shifts, or compromise formations.

2. We do not, as a rule, talk about eliminating psychological conflict, and we pretty much accept the presence of conflict as one of the givens of being alive. We do hope that the analysis will result in a more favorable resolution of the central conflicts that existed prior to treatment.

3. We do not think about analyses being complete or finished. We recognize that an analysis can be terminated successfully even though more analytic work could be carried out.

4. We no longer insist that transferences be completely resolved, i.e., analyzed.

5. We no longer think about "overcoming" resistances. We try, rather, to analyze them and to learn more about their sources, their structures, and the specific unpleasurable affects to which they respond. We anticipate that analytic work will lead to greater access to the unconscious derivatives associated with these resistances.

6. We do not seem to hear much about parameters. I suspect that one reason for this is that we are less likely to feel that a particular intervention is the only correct one in a given situation, and more likely to recognize that technical errors on the part of the analyst are inevitable. With greater interest in and emphasis on the psychoanalytic process, we assume that we will have opportunities throughout the analysis to deal with these difficulties in ongoing analytic work.

7. Insight is still a highly valued desideratum. We aim for the patient's achievement of it and we look for evidence of it in our analytic work, but I do not believe that it is still considered the sine qua non for a successful psychoanalysis.

8. The analysis of dreams is no longer considered "the royal road to a knowledge of the unconscious activities of the mind" (Freud 1900, p. 608). It is my impression that most analysts no longer routinely carry out a formal analysis of each and every element of manifest dream content.

9. We no longer focus on the transformative effects of "good hours" (E. Kris 1956), but instead are content with plenty of "not so good hours."

10. We increasingly acknowledge the importance of the analyst's affective participation in the analytic work.

Reflection on these ten points raises the question of whether what is described represents a greater modesty and a more realistic assessment of what psychoanalysis can achieve, or whether we are dealing with something like what Gilbert Murray once called the failure of nerve that overtook the pagan Greek world before it was destroyed by Christianity. Whatever their merits, the ten trends enumerated above tend to obscure the line of demarcation between psychoanalysis and psychoanalytically oriented psychotherapy. At its very best, analysis can give the patient a new way of understanding him- or herself, a kind of insight that enables the patient to understand what happened in his or her life that determined the unique nature of the patient's strivings. How far analytic technique can be modified along the lines suggested by Weinshel, while still keeping its uniqueness, has not as yet been determined.

There are a number of points in Weinshel's essay with which I do not concur. For one thing, the dream has retained for me a special position, and I continue to regard it as the most valuable communication from the unconscious of the analysand to the analyst

(Bergmann 1966). I agree that Freud's archaeological metaphor no longer serves as a measure of progress in the analysis, but childhood memories, especially when they emerge in a dynamic context with current problems, are to me still of great significance. I also do not share Weinshel's belief that the concept of Kris's "good hours" has lost its pivotal position in psychoanalytic technique (Bergmann 1993).

I will conclude my historical review by noting that, in 1995, Wallerstein published a large volume entitled *The Talking Cures,* which dealt at length with the evolving relationship between psychoanalysis and psychoanalytically oriented psychotherapy. Instead of regarding analysis as the best treatment anyone could hope for, as Freud did, the new approach offered the belief that

> . . . treatment should be fitted to the clinical exigencies and needs of the patient, contrary to the stance of Freud's days, when psychoanalysis had been conceived as the only scientific and truly etiologic treatment approach to which the patient should be fitted if at all possible. [p. 88]

DISCUSSION

In 1996, Sandler and Dreher published a monograph subtitled "The Problem of Aims in Psychoanalytic Therapy." They concluded that mental health is specific to each patient and to his or her particular life situation, and the aims of psychoanalysis vary according to the value systems of both analyst and patient (p. 121). Analytic goals must take into account all the patient's personal limitations and particulars, as well as his or her social or economic context (p. 122). In spirit, the book's philosophy is close to Weinshel's, emphasizing selectivity and modesty. Here, as well as in Weinshel's paper, analysts appear to be more realistically grounded. And while such modesty is always becoming, I cannot help but feel that we are seeing evidence of a loss of nerve.

As I see it, the issue of goals became important because of certain contradictions inherent in the very nature of Freud's creation of

psychoanalysis. Insofar as the analyst is the guardian of the process of free association, his or her efforts must be directed toward making it possible for the analysand to associate as freely as possible (A. Kris 1982). If that approach is fully pursued, both analyst and analysand can become caught up in the thicket of the unconscious, years can pass, and the analysis may be in danger of succumbing to the primary processes. Therefore, the other function the analyst must keep in mind is support of the reality principle, which may at times become inimical to the process of free associations. Furthermore, in my own clinical approach, I have stressed my indebtedness to E. Kris; his 1956 paper was decisive in my development as an analytic clinician and analytic teacher, as I pointed out earlier:

> Although psychoanalysts had long known that certain analytic hours were regarded by both patient and analyst as particularly productive, Kris was the first to examine such an hour systematically. He described such hours as generally beginning with the patient recounting a recent experience. The analysand was restless, he then expressed negative feelings toward the analyst. But at a certain point in the hour a marked change occurred. Everything seemed to fall into place. A dream was told, and there was no resistance to associating to it. New memories became available. Often all that the analyst needed to do was ask one or two questions and the analysand summed up by himself or herself.
>
> One of the implications of Kris's concept of the good hour is that it is the analysand's property and cannot be willed either by analyst or analysand. [Bergmann 1993, pp. 379-380]

I see the analyst not only as guardian of the patient's free associations, but also as midwife, facilitating the birth of the "good hour." The "good hour paper" had its roots in Hartmann's (1964) ego psychology; as long as neurosis prevails, the ego has to employ its energy in countercathexis, keeping unacceptable unconscious ideas and wishes in a state of repression. Analysis allows the ego to relax its grip, freeing the ego to employ its energy in integration and the

undoing of isolation. Kris's good hour becomes more likely to occur once more energy is available to the ego for the work of integration. Analytic conceptualizing during the Hartmann era reached the high point of its contribution to technique with the concept of the good hour (Bergmann 2000).

I find it useful to divide the analytic process into three phases. In the initial phase, the analyst is prepared to do everything in his or her power to ensure that the analytic process can get started. In practice, that means understanding the forces within the analysand that oppose the analytic process. If the unconscious mind's need to destroy the analysis is not made clear by the analyst, the analytic endeavor will be overcome by the repetition compulsion that is opposed to any change for the better in the intrapsychic equilibrium.

Once this temptation has been mastered and the analysand is no longer trying to destroy the analysis, the goal of the analyst shifts to preventing a compromise formation from taking place too early. These compromise formations usually consist of a change for the better in life goals, such as may occur when an analysand marries without fundamental intrapsychic change. In practice, it may be necessary to understand and overcome an unproductive stalemate that has set in during the middle phase of the analysis. Often, this requires the analysis of transference resistance, which may have achieved dominance over the analysand. The analyst can help by continuously emphasizing free association, and not deflecting the hour away from its inherent course. It is during this phase also that the analyst must work in such a way as to maximize the possibility of the number of good hours.

Finally, once this phase has accomplished its purpose, the analysis enters the termination phase. In a paper written in 1997, I pointed out the particular perils of this phase. Here, either leaving the termination process up to the analysand, as Ferenczi (1927) proposed, or its opposite—arbitrarily setting the date of the ending by the therapist, as Freud did with the Wolf Man—can be detrimental. Deep-seated character problems may escape analytic scrutiny and appear only during the last phase, when the analysand cannot free him- or

herself from the tie to the analyst. Termination may at times require the creation of a new "ego function" that the analysand must develop. Successful termination cannot take place when either superego or id are still powerful. Only the ego's adherence to the reality principle can bring the analysis to a successful conclusion.

In my view, the distinction Ticho (1972) made between treatment goals and life goals needs emphasis: treatment goals vary and are dependent on particular stages in the analytic process, while life goals, which deal with such subjects as marriage, divorce, the wish to have children, single parenthood, and homosexuality, should be left strictly to the analysand to decide. Far too often, psychotherapists and psychoanalysts have found it difficult to leave all life goals to their patients themselves.

I would like to conclude by noting that the maintenance of a sort of double stance—giving the analysand maximal free space to pursue his or her own life goals, and at the same time, keeping control over the changing goals of the analytic process itself—lies at the very core of what it means to be a psychoanalyst. It constitutes our professional ego ideal.

As we enter the year 2001, we are well aware of very rapid changes taking place in our culture. Every present-day analytic case teaches us that the basic problems encountered by children in their formative years are not significantly different from those that Freud observed. Unloved children, children who suffer illnesses and other traumatic experiences, those subjected to social catastrophes, and those who encounter deviant parents and hostile siblings are with us now, just as they were in Freud's time. But as adults, these persons encounter a very different culture, one that offers different deprivations as well as different opportunities. In this new culture, the interaction between adult opportunities and early deprivations is very different. Thus, as analysts, we have the additional task of grasping the complexities of the changing culture encountered by both our patients and by us. This unique culture has imposed different life goals on our patients, and whether these life goals require a reexamination of our treatment goals remains to be seen.

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Psychoanalytic Quarterly, LXX, 2001

PSYCHOANALYSIS AND LIFE

BY EMANUEL BERMAN, PH.D.

> Every New Beginning has to take place in an object-relation.
> —M. Balint (1936, p. 213)

Not long ago, a world-renowned analyst presented a case in an analytic institute. The presentation was eloquent, the explanations of the analysand's psychopathology and transference patterns were fascinating, and the audience was intrigued. Most of the lively and sophisticated discussion following the lecture focused on conceptual issues. Only one participant, somewhat hesitantly, asked a banal question: Did the analysand's problems get any better?

The lecturer appeared a bit embarrassed by the unexpected inquiry, and gave a tortuous answer, which most listeners translated to themselves as indicating that so far—after several years of analysis—the analysand had not improved. In later, informal conversations, one observation was prominent: if not for this one irreverent question, the topic might not have come up at all.

Another world-renowned analyst, in a recent Internet discussion of a paper he had published in a major journal, responded to similar challenges with the following: ". . . to make people feel better? Isn't that what the pharmaceutical companies promise?"

Indeed they do. And to my mind, the challenge they present to us—as well as those posed by various shorter and cheaper psychotherapy methods—should be met head on, not scornfully dismissed. In a reality in which clinical psychoanalysis repeatedly comes under attack as dated and ineffective, as self-absorbed and cultish, we analysts cannot afford to disregard the issue of the relevance of our work to people's lives.

WHOSE GOALS ARE THESE, ANYWAY?

> I know of no other adequate rational motivation for turning to analysis—and persisting in it through its deeper vicissitudes—other than the hope for relief of personal suffering.
>
> —L. Stone (1984, p. 425)

Making the unconscious conscious; bringing the ego in where the id was; strengthening the ego so that it can be more adaptable; making the superego less persecutory and more flexible; encouraging separation and individuation; helping in the transition from the schizoid-paranoid position to the depressive position; striving toward greater cohesion of the self; deepening one's object relations, or moving from object relating to object usage; making one more comfortable and at home in one's body—these goals and many others have been offered during the past century as quintessential in clinical psychoanalysis.

Before we hasten to add our own formulations, I believe we need to address some preliminary questions: Does the concept of goals present any inherent difficulties for psychoanalysts? Should we strive to formulate universal goals, or are the goals in every analytic process unique? When a patient enters an analysis, who chooses the treatment's goals?

I will begin with the latter issue. I have recently been editing a Hebrew edition of Freud's technique papers, and one aspect that struck me upon rereading them was Freud's powerful, paternalistic authority position vis-à-vis his patients, probably a characteristic stance for a physician in his milieu. It is recognizable in his tone: "When there is a dispute with the patient whether or how he has said some particular thing, the doctor is usually in the right" (1912, p. 113); "One must be especially unyielding about obedience to that rule . . . " (1912, p. 119); and so on.

Culture has changed since then, and the awe toward physicians and other experts has diminished. Many of our present analysands are not that obedient and are much more critical of our authority. Financial arrangements that were acceptable in Freud's time (such as charging a full fee for sessions cancelled in advance) may today

arouse angry protests (Bader 1997), leading at times to an abandonment of the analysis if strict maintenance is attempted. The number of sessions per week and the use of the couch can no longer be simply imposed.

When Kernberg (1999) discussed indications for psychoanalysis versus those for psychoanalytic psychotherapy, he did not allow for the possibility that many such choices are nowadays made mostly by patients. In the experience of many Israeli analysts, at least, the major difference between patients in analysis and patients in psychotherapy often does not reside in any diagnostic criteria, but in the fact that the former have consented to be in analysis (which most analysts are eager to practice), while the latter declined.

Analysands start analysis with goals of their own, both conscious and unconscious, and can be understood as having unconscious plans for achieving these goals (Weiss 1998). Analysts also have their goals, and the issue of what will be the goals of the analytic dyad becomes a topic of interpersonal negotiation (Mitchell 1993). This negotiation may have open, conscious components, as well as subtle, preconscious, or unconscious ones. It constitutes a lively, continuous dialectic, which keeps evolving as long as the analysis lasts (and in the minds of both partners after its completion), though its peaks are likely to be at the opening phase and at the termination phase.

Failures in the negotiation process may cause this dialectic to collapse. One example of this occurrence would be a domineering analysand's casting aside of the analyst's agenda, with demands for full devotion to his or her proclaimed agenda (be it the removal of a particular symptom, finding or divorcing a spouse, suppressing certain sensitivities, or the like). The analyst's feeling intimidated, becoming reluctant to make certain interpretations because they will be scorned or dismissed, or giving up on some topics as "taboo" may indicate such a collapsed dialectic. Such rigidity usually signifies a suppression of inner voices in the analysand, an issue to which I will return; the intrapsychic and the intersubjective can never be fully separated.

The opposite kind of collapse occurs when a domineering analyst imposes certain theoretically derived goals, while the analysand's

goals are interpreted away as resistant, concrete, or shallow ("feeling good is what pharmaceutical companies promise"). A compliant analysand may acquiesce (Weiss 1998), but at the price of experiencing analysis as taking place in an authoritative setting requiring submission, not really one's own place. Paradoxically, this defeats one of the analyst's potential goals, that of fostering personal autonomy.

The Freud–Ferenczi conflict can be conceptualized against the backdrop of this issue (Berman 1996, 1999). Freud's emphasis on the universal scientific goals of psychoanalysis—an extension of his decision, after graduating from medical school, to opt for laboratory research rather than for medical practice—made him see his patients, at times, primarily as a source of material to confirm, correct, or elaborate his theoretical formulations. This focus played a role in his strong objection to any *furor sanandi* (1915, p. 171). In Freud's writings, we find patronizing comments about patients "of only moderate worth" (1912, p. 119); and some of his blunt remarks in private ("Patients are a rabble . . . [they] only provide us with a livelihood and material to learn from" [Ferenczi 1932, p. 93]) made Ferenczi suspect that Freud—following certain disappointing experiences with patients—became alienated from them, and started to abuse his patients' trust by pursuing his own goals irrespective of the patients' goals (Ferenczi 1932, p. 186). This could constitute another example of a collapse of the negotiation process.

Psychoanalytic literature is mostly written from the analyst's point of view. Even though all analysts have also been analysands, their subjective experiences as analysands (and those of other analysands) are rarely discussed in writing, and the picture we get of the analytic process is therefore tilted (Berman, in press). While the present paper, too, is written mainly from the analyst's point of view, I also attempt to draw upon my experience as an analysand in two analyses, as well as on my cumulative impressions as a supervisor, and as a friend and colleague of dozens of analysands who have spoken with me of their analyses throughout the years.

The analyst–analysand negotiation process is influenced by, among many factors, commonalities and variances in the values and beliefs of the two partners. Without going into the subtler differen-

tiation of values typical of various analytic schools, one might say—as the simplest example—that psychoanalysts usually favor fuller expression and integration of inner experiences, and this value may be at odds with the goal a particular analysand may wish to achieve, of learning to more effectively suppress certain painful feelings and better repress traumatic memories. An effective analysis brings about a developmental process, through which such gaps may be surpassed and transformed; but the analysand may need deep reassurance that the analyst will not attempt to impose his or her values (including those relating to religion, politics, and sexual orientation) before allowing the further evolution of such a process.

While open conflicts about values may become a striking obstacle in forming joint goals for the analytic dyad (goals that could be conceptualized as an aspect of a working alliance), this does not indicate that a commonality of conscious values and stated goals—as may be more widespread in training analyses, for example—is a guarantee against deeper and less visible difficulties in the process. We must remember that there is inherent conflictuality in analytic goals, even if we momentarily limit their exploration to an intrapsychic level.

THE INHERENT CONFLICTUALITY OF GOALS

> The result is a plural or manifold organization of self, patterned around different self and object images or representations, derived from different relational contexts. We are all composites of overlapping, multiple organizations and perspectives, and our experience is smoothed over by an illusory sense of continuity.
>
> —S. Mitchell (1993, p. 104)

Speaking of the analytic process as an interpersonal negotiation alone could be understood to imply that each partner in the dyad comes with a unitary and consistent set of goals; such simplistic assumptions are of no value. Notions of smooth coherence and inner unity are

foreign to psychoanalytic thinking. Adler favored teleology, believing that a person's life is shaped by the impact of unitary goals for which he or she strives; while Freud's causal models (and those of most analysts ever since) put conflict and overdetermination at center stage. This makes conscious goals an epiphenomenon to be carefully examined, possibly pointing toward rationalizations and other defensive operations that mask deeper motives, ones which are harder to express, as well as inner conflicts about one's goals.

Another way to formulate this concept is to speak of the simultaneous operation of numerous goals on different levels of consciousness, goals that may represent conflicting and unintegrated aspects of one's personality. Earlier literature might have discussed this multiplicity as "id goals" versus "superego goals," or as "libidinal ego goals" versus "internal saboteur goals" in Fairbairn's terms, but all such divisions may be too schematic and reified to account for the unique inner dissociations and conflicts of a particular individual. An intersubjective view holds that the enormous complexity of any interpersonal negotiation results from the simultaneous and mutually interconnected operation of dyadic dynamics and of inner dialectics within each partner, whose inner conflicts are likely to themselves have evolved in the context of past relationships. The analysand's goals in analysis—like anyone's goals in any significant situation—are unavoidably conflictual.

For example, a male analysand who consciously defines his initial analytic goal as to overcome guilt and inhibitions in order to be freer to have extramarital affairs (a wish that could be interpreted as signifying a manic victory over his wife) may gradually disclose a preconscious yearning for renewed sexual closeness with his wife (with the analysand feeling reluctant to acknowledge this yearning, which would make him more vulnerable to painful rejection); while the analysand's dreams make his analyst conclude that unconsciously, the analysand wishes to be relieved of the burdensome tensions of adult genital functioning, and to be held and caressed as a little boy once more.

The understanding and working through of such conflicts, in the search for newly formulated goals, is unavoidably colored by the

analyst's own countertransference (including personal experiences in marriage), theories (are extramarital affairs conceptualized through a focus on aggression and deception, or on a search for one's true self as discoverable through fuller intimacy?), and social values ("family values," versus a greater emphasis on individual fulfillment). These different levels are interrelated, as a full self-analysis of ourselves will reveal, given the emotional significance of choosing theories or identifying with ideologies.

While the inner conflictuality of patients' goals is widely recognized in analytic literature, its counterpart regarding the analyst's goals is not always acknowledged. In situations such as that just described, the analyst's conscious goal, often well formulated in theory-derived terms, may clash with "hidden agendas" that might emerge only in the analyst's own analysis, in personal supervision (Berman 2000b), or in self-analysis. Such a secret goal may derive, for example, from a fantasied wish to test through the analysand the experience of extramarital affairs, about which the analyst feels conflicted, or from a hope to restore the analysand's marriage, which can be traced back to the analyst's childhood wish to save the crumbling marriage of his or her parents. When the analysand becomes concerned about the analyst's bias, possibly expressed through interpretations manifestly promoting insight but latently encouraging or discouraging the act of having an affair, it may be that secret countertransferential goals have indeed become detectable.

In other cases, the goal of helping the analysand become more autonomous and eventually terminate may clash with, for example, an unconscious goal of keeping the analysand forever in a state of grateful dependency. Once we acknowledge the ubiquity of complex countertransference, which is by no means more rational or controllable than transference, any expression of the analyst's goals must be taken with a grain of salt.

Let me give one more example, this one from a case study explored in detail elsewhere (Berman, in press). An attempt to study the apparent failure of a particular analysis pointed to the impact of discrepancies within the analytic dyad, both in conscious values (e.g., the analyst's investment in intimate mutual relationships, and the

analysand's belief in the value of structured and guarded relationships), and in related unconscious transferential goals (e.g., the analyst's wish to re-create in the analysis aspects of his egalitarian relationship with his father, and the analysand's wish to find in him a stricter father who, as in her childhood, will protect her by his firm rules from the chaotic world of her mother). While in that case much insight was achieved after the premature termination, an earlier opening up and working through of such intersubjective dynamics, combining the analyst's self-analysis with a fuller exploration within the analysis itself, may prevent the collapse of the unconscious negotiation of goals within the analytic dyad.

THE DIALECTICS OF GOALS AND GOALLESSNESS

> In doing psycho-analysis I aim at:
> Keeping alive
> Keeping well
> Keeping awake
> I aim at being myself and behaving myself.
> —D. W. Winnicott (1962, p. 166)

Let me point to another common—possibly universal—conflict in the analyst: the conflict between goals (any goals) and goallessness. Goal-directed behavior is predominantly experienced as linear, structured, oriented more toward *doing* than toward *being*. Spontaneity and relaxation, Freud's "evenly hovering attention," Ferenczi's "being natural," Winnicott's "being with" and playing, Bion's "without memory and desire," all imply overthrowing, at least momentarily, the tyranny of goals.

An analysis, it was once suggested, "does not naturally . . . proceed from A to B. Its course is something else—more like the course of a neurosis or a love affair" (Lewin and Ross 1960, p. 52). The concept of goals tends to imply "proceeding from A to B," introducing a superego strain into our clinical work. As with any emphasis on

desiderata, the goals concept always runs the risk of being mobilized for utopian zealousness, leading to an intolerance of the complexity and imperfection of actual reality, which is constantly compared to desirable end-states (Berman 2000a).

Wallerstein (1965), who may have been the first to pinpoint the dialectic of goals and goallessness, spoke of the paradox "between goallessness (or desirelessness) as a technical tool marking the proper therapeutic posture of analytic work and the fact that psychoanalysis differentiates itself . . . by positing the most ambitious and far-reaching goals" (p. 749). He raised a crucial issue, but I feel that the term "technical tool" does not acknowledge its full significance. All the varied notions I have mentioned convey profound beliefs about the nonlinearity of psychic change, about the value of open-ended situations that allow us to be surprised by ourselves and by the other: "Attunement . . . is 'aimless' in the sense that it cannot legislate in advance what will emerge from the playful and spontaneous encounter between therapist and patient" (Holmes 1998, p. 237). These notions are therefore much more than technical tools.

When Winnicott humorously described his aims as keeping alive, well, and awake (while deliberately avoiding any metapsychological definitions of aims or goals), he also told us something on a serious level, something substantial about the kind of presence and relating that could be used by the other to become more alive, to feel well, and to awaken to the fuller potentialities of "being oneself." Here, too, we may notice a change of *Weltanschauung*. In a generation dominated by metapsychology, by a belief in definitive causes and in overarching, objective, organizing principles, the expectation to formulate theoretically derived, general goals for psychoanalytic treatment was natural. For a generation that has become more skeptical regarding general truths about human nature,[1] and that gives priority to more modest clinical theories (Wallerstein 1988), such universal goals do not fit as well, and may even arouse our suspicion as causative of a fetishistic ossification of live processes.

[1] Skepticism regarding Freud's metapsychology is matched by the decline of grand theories in other areas of the humanities and sciences.

While Renik (1999) expressed concern that, by relating change in analytic technique to the democratic or postmodern *Zeitgeist,* "we dismiss it as determined by political aims or academic fashion" (p. 523), I believe that such connections are inevitable, whether we acknowledge them or not. We are all continuously influenced by our cultural milieu. Indeed, the "evolution toward less self-importance and more candid self-exposure by analysts . . . has been motivated by immediate, pragmatic considerations" (Renik 1999, p. 523); but our capacity to become pragmatic rather than doctrinaire has been strengthened by a certain cultural climate, and analysands' capacity to benefit from our candid self-exposure has been correspondingly increased by this same climate.

More modest and relative goals, better geared toward unique (and possibly transient) cultural and individual needs, sound more convincing to our contemporary ears, more suitable for a secular, pragmatic, realistic psychoanalysis. Still, even these may be counterbalanced by a critically deconstructive tendency, which exposes the limitations and inner contradictions of any goal (and any technique), subverting potential idealizations. This climate may explain the growing impact of Winnicott's work, in which paradoxes are not to be resolved.

Goallessness, however, may arouse guilt in the analyst: "Are we going anywhere, or are we wasting our time?" Such a conflict may appear in the analysand as well. "I realize I want to go on because it's nice to meet with you, not for the analysis"; "Sometimes it crosses my mind that it would be great to continue forever"—these are words likely to convey both warm appreciation and concern.

Although later in this paper I will express my own concerns about endless analyses, I feel that part of the yearning to avoid termination is related to the *being* dimension of the analytic bond, which, to some extent, makes it into a goalless relationship—or, in other words, turns the closeness into a goal in itself, just as may happen in an intimate friendship, in a lasting romantic relationship, or in affectionate parent–child ties that outgrow the functional aspects of child rearing. Various theoretical notions of attachment, object relations, and subject relations lend significance to the capacity

to calmly enjoy this kind of closeness without worrying about its "outcome."

More specific goals, which constitute the other end of this dialectical tension, cannot be the analyst's alone nor the analysand's alone; and they need not be universal. Proposing binding universal goals will never do justice to the unique personalities of analysts, analysands, and analyst–analysand dyads. In the following sections of this paper, I will therefore not propose what should be "*the* goals of psychoanalysis," but instead will discuss goals that are personally meaningful to me, and which I often present, explicitly or implicitly, to my analysands, as part of the attempt to patiently negotiate the evolution of our joint goals.

ON INTERNAL AND EXTERNAL GOALS

> Transitional space breaks down when either inner or outer reality begins to dominate the scene, just as conversation stops if one of the participants takes over.
>
> —A. Phillips (1988, p. 119)

A prominent characteristic of the psychoanalytic approach is its interest in what lies beneath the surface, in what is not conscious, not openly formulated, not directly observable. Clearly, the goals of any analysis cannot be stated in behavioral or psychiatric terms, since we know all too well that the same factual outcome (e.g., the analysand got married or divorced, became a parent, achieved professional recognition, or quit a job) may have a multitude of inner meanings, some diametrically opposed to the conventional significance attributed to such an outcome.

At the same time, if this caution becomes transformed into a condescending attitude toward "external" reality, we are at risk. Winnicott (1945) warned against such dismissal: "Fantasy is only tolerable at full blast when objective reality is appreciated well" (p. 153). A belittling view of actual life realities may give the exploration of goals a solipsistic quality. While external facts by themselves could never

serve as the criteria for analytic success, substantial inner changes—changes in self-experience, in one's inner object world, or in the rigidity of one's character armor and defenses—can and should be expected to have visible manifestations in the analysand's actual life, away from the couch: "A real change occurring in the absence of action is a practical and theoretical impossibility" (Wheelis 1950, p. 145).

If an analysand's friends or family members consistently say that in spite of his or her claims for improvement, they themselves do not notice any change, there is, in the long run, a reason for concern. Undoubtedly, when an analysand quotes such complaints in analytic sessions, this may be an indirect way of expressing ambivalence. But this does not preclude the possibility that the individuals quoted do indeed entertain their own doubts, and that they may have a valid point.

An analysis that deals exclusively with what happens in the consulting room, and interprets all the analysand's reports of his or her outside life as indirect expressions of transference toward the analyst, poses the danger of a new reductionism. One of its unspoken implications may be that the analytic relationship is "between a highly important, omnipresent object, the analyst, and an unequal subject who at present apparently cannot feel, think or experience anything unrelated to the analyst" (Balint 1969, p. 169). Such an approach may be ill-equipped to fully evaluate the outcome of the analysis; "this idealization of process over outcome can sometimes hamper our ability to study how our technique helps people" (Bader 1994, p. 254). In a self-contained process inattentive to outside life, we may be less capable of differentiating changes in the analytic relationship that can gradually be generalized to other contexts as well, from a dedication to an analysis that becomes a substitute for any other investment in life—a danger I will explore in more detail later on.

Numerous idealizations in psychoanalysis can become persecutory, contributing to a difficult atmosphere in many psychoanalytic institutes and organizations (Berman 2000a; Kernberg 2000). This trend may involve an uncritical belief in the universal value of in-

terpretation, of empathy, or other factors of treatment (Berman 2000c). Another example indicative of such a problem is the idealization of structural change as utterly distinct from an inferior clinical or symptomatic change. I agree with Werman (1989) that this distinction "has outlived whatever usefulness it might ever have had" (p. 120). Wallerstein (1989), in summarizing an extensive follow-up study of forty-two patients, concluded that changes defined as analytic (structural), as opposed to *merely* therapeutic, were in many cases "quite indistinguishable" (pp. 586-587). The difficulty in acknowledging such findings may indeed be attributed to "the tendency to neglect therapeutic aims in psychoanalysis" (Bader 1994).

While any conception of analytic goals unavoidably involves some notion of achieving significant and lasting changes, many attempts to categorize or rank-order the quality of such changes appear to serve mostly a polemic/competitive need to glorify certain analytic theories and techniques while denigrating others ("my work is deep, your work is shallow"). The determination to keep psychoanalysis totally distinct from psychotherapy (Berman 2000a) may serve such an agenda in internal professional politics, as well as in the self-image of analysts. The exploration of differences between psychoanalysis and psychotherapy is of interest, but in a social reality in which all the talking cures come under harsh attack, an overemphasis on such inner dividing lines may serve the narcissism of small differences while neglecting the crucial contemporary debate about the legitimacy and value of psychoanalytic treatment as a whole.

SELF AND OTHERS

> Every neurotic symptom means also a distorted object-relation, and the change in the individual is only one aspect of the whole process.
>
> —M. Balint (1950, p. 121)

A good example of the inner-outer dialectic is the issue of object relations. One's inner object world, the patterning of one's lasting

representations of the other and their affective coloring, is a major issue in psychoanalysis. Most of us would agree that this inner world is influenced by actual self–other ties in childhood (even if we disagree about the relative weight of such actual ties in comparison to inborn drive–fantasy formations), and that it in turn influences one's actual self–other ties in adult life. One of the potential expressions of substantial changes in an analysand's inner object world would therefore be changes in the quality of actual relationships, both with the analyst and with significant others in the analysand's life outside the consulting room.

Numerous ideas have been put forward describing variations in the quality of self–other relations: Klein's transition from part objects to whole objects, from a schizoid-paranoid experience of objects to a depressive experience, and from magic reparation to realistic reparation; Winnicott's shift from object relating (toward "subjective objects") to object usage (recognizing "objective objects"); Kohut's evolution from archaic selfobjects toward mature ones; or, most recently, transition from objects to subjects (e.g., Benjamin 1995). In all these divergent formulations, the more mature form of relating involves a greater capacity for recognition of the other's uniqueness, and consequently truer mutuality.

Ogden (1989) spoke in this context of a "depressive" capacity for historicity, in which processes can be explored. Within such historicity, an object relationship can be understood as going through mutually determined transformations. For example, the dead-end rhetorical question "How could I have married such a monster?" may be replaced by a painfully real one: "What went wrong in our relationship so that we became monstrous toward each other and lost the good things that brought us together initially?" To give another example, a preoccupation with who you want your child to be (leading to disappointment about the child's failure to comply with this yearned-for image) may be replaced by greater curiosity as to the child's actual personality, and the way it influences (and is molded by) your evolving relationship with this child. To address such topics, listening to the other becomes a necessity.

When such listening continues to be impossible, the other's point of view may often be distorted through projective mechanisms and scapegoating, dismissed out of self-righteousness ("What she says about me is crazy, manipulative, insincere"), anxiously disregarded due to an equation between recognition and submission ("If I understand him too much, I'll have to succumb to his wishes"), cast aside in a climate of entitlement, or otherwise discounted. When such patterns gradually change, this naturally has enormous potential consequences for the other, whose point of view is eventually better recognized and taken into account. A dialogue becomes more attainable.

The particular aspect of understanding the other's point of view that I wish to emphasize here is an understanding of the other's view of me (Laing 1961). One's well-being is often influenced not only by insight into one's own needs and motives, but also by insight into one's impact on significant others and one's reflection in their subjective experience. An analysis with an exclusively intrapsychic focus may go a long way toward bringing the analysand into closer contact with early memories and unconscious fantasies, and yet leave the analysand blind to his or her impact, which may be a key to the success or failure of one's actual relationships. When such impact is never explored, we may unwittingly reinforce the analysand's self-centeredness, a passive and victimized self-image, or a sense of entitlement.

The intrapsychic and the intersubjective are, of course, closely connected. An unconscious fantasy—originally formed in the context of one's early relationship with one's parents—may determine one's attitude toward one's spouse or children, and so forth. But this connection is far from being self-evident and malleable, so that the elucidation of the fantasy will of itself change present and future relationships. To the contrary, a direct exploration of these connections appears to me to be an inherent aspect of analytic work, and only analytic treatment can then supply the full picture of self–other relations in their multilevel, inner and outer, actual and fantasized, intersubjective com-

plexity. The capacity to observe a rich range of actualized object relations—and to figure out their subjective significance for both sides—is a significant component of psychoanalytically oriented group therapy and family therapy, where we can observe each patient's relations with numerous others, including family or group members, relations that always have transferential components which reveal the impact of variable inner object representations.

In an individual analysis, such a goal can be served in two complementary ways. One is through close attention to the analyst–analysand relationship, to transference and countertransference in their broadest definition and in their fullest complexity.[2] The other way is through attentive listening to the analysand's descriptions of his or her central relationships outside the analysis, past and present, and to their subtle affective nuances and fluctuations. I do not see these two paths as mutually exclusive; they may facilitate and enhance each other.

In line with my assumption that I have a specific impact, I see no reason to assume that all my analysand's object-related issues will be played out fully with me alone. This is one of the reasons I am also interested in other relationships the analysand may have, in which other unique individuals (of different age, gender, and character than mine) activate different relationship patterns in the analysand. A comprehensive understanding of an analysand's actualized relational world (including the analytic relationship and all other central personal and professional relationships, past and present, that are emotionally significant) allows a fuller picture of the analysand's inner object world. This fuller picture may

[2] The broad definition I refer to implies seeing the transference-countertransference cycle as a comprehensive process of mutual influence; "transference is the expression of the patient's relations with the fantasied and real countertransference of the analyst" (Racker 1968, p. 131). I do not assume that the analysand's experience of me is all displaced or projected, and I attempt to listen carefully to indications of the way my unique personality and unique countertransference also influence the process, for better and for worse (Gill 1982).

come close to the picture that would emerge in an analytic therapy group, in which each patient's various (vertical and horizontal) transferences combine into a meaningful pattern. Another case in point would be training analyses, in which we often discover unique transference patterns toward various faculty members, as well as splits between the various transference figures (including analyst, supervisors, and teachers, among others) in the candidate's life. In a particular instance explored more fully elsewhere (Berman 2000b, pp. 283-284), I noted that an analysand's childhood experiences with regard to his parents' divorce were partially re-created, and subsequently understood and worked through, in a transferential matrix involving his analyst and one of his supervisors. I do not view these splits as primarily defensive or as indicating resistance (Berman 1995), and I find their detailed analysis to be potentially quite fruitful.

Undoubtedly, in some instances, extra-analytic relationships involve displaced aspects of the analytic transference; unexpressed or unacknowledged disappointment with the analyst may be split off and displaced to a supervisor or to one's spouse. Yet I see no reason to assume a priori that this is always the case. To give the simplest example, some emotional dynamics specifically related to male–female relations may emerge in a cross-gender professional or personal relationship, while not emerging at all in a same-gender analysis, and their interpretation as a displacement may be presumptuous.

When we actually discover strong commonalities between different relationships, on the other hand, this could be evidence of powerful points of fixation in which the uniqueness of the actual other disappears under "the shadow of the [inner] object" (Freud 1917, p. 249). When this is the case, the analytic exploration of such common patterns—such elements of repetition compulsion—is facilitated by the analysts's capacity to pinpoint the pattern in several contexts simultaneously (in the consulting room, in the analysand's marriage, in a professional context, and so on), rather than putting all the weight on the analytic dyad alone.

COMPLEMENTARY IDENTIFICATIONS, INTERSUBJECTIVITY, AND SELF-DISCLOSURE

> An analyst who is, as far as the patient can see and know, always helpful, kindly and understanding, may seem to that patient to be a wonderful man . . . [but] he may not have the feeling of having been fully known. This analyst will not have *lived through* the patient's childhood. This analyst will not feel the frustrations of the parents or the destructive ability of the child who is furious with the parent.
>
> —C. Bollas (1987, p. 253, italics in original)

Close attention to countertransference reactions is indispensable in understanding the full, mutually transferential cycle characterizing the analytic dyad. Racker (1968) identified two major components in countertransference: concordant identifications, in which we find ourselves "in the analysand's shoes," and complementary identifications, with the analysand's objects. When he first presented these formulations in 1948, Racker spoke of the "complementary attitude" (Deutsch's [1926] original term) as allowing understanding but preventing the analyst from reacting understandingly, which would become possible only when the analyst had "analysed and overcome" his reaction and was "able to identify himself with the patient's ego emotionally as well" (Racker 1968, p. 124). In a later paper (written in 1953), Racker appeared more tolerant of the unavoidable appearance of both kinds of identifications, but still related empathy to concordant identification and to sublimated positive countertransference (1968, p. 136). In a still later paper, in 1956, Racker emphasized that through complementary identifications, "the analyst acquires a further key of prime importance for the understanding of the transference" (1968, p. 175). I would add that complementary identifications are also a key to our fuller understanding of extra-analytic relationships, complementing their description from the analysand's conscious point of view.

Tansey and Burke (1989) further pursued Racker's line of thought by emphasizing that the objects in one's life also represent aspects of one's self, and therefore "the potential for an empathic outcome also lies in the successful processing of complementary identifications" (p. 58). While the complementary emotional state may be momentarily adversarial, "what the therapist is experiencing at a particular moment may very well be something that the patient himself has experienced," and therefore "the initial complementary identification serves as a vehicle for an eventual concordant identification" (p. 59).

This idea resonates with Ogden's (1983) analysis of "the formation of two new suborganizations of the ego, one identified with the self in the external object relationship and the other thoroughly identified with the object" (p. 234). Ogden concluded that Racker's complementary identification "involves the therapist's unconsciously identifying with the aspect of the patient's ego identified with the object" (p. 234). The subjective experience of the analyst, in whom such identifications may arouse guilt due to their unempathic and "treacherous" nature, is therefore misleading, since the identifications potentially form a springboard for a much richer and more complex empathic understanding. "Concordant and complementary countertransference identifications coexist and have an interdependent, dialectical relationship with each other, growing out of the empathic bond that arises when one person attempts to give care to another" (Feinsilver 1999, p. 274).

An attempt to base one's analytic work only on concordant identifications—out of an idealization of empathic immersion, of "being at one with the analysand"—sidetracks this dialectical relationship. It is problematic for several reasons:

> Such an attempt is forced, and may lead to inner censorship of parts of the analyst's multifaceted spontaneous experience with the analysand, which is in its totality a major source of insight into the analysand's emotional life (Bollas 1987). If aggressive reactions, for example, are cast aside by the analytic superego, we

may end up with a depleted "prescribed countertransference" (Berman 2000c).

Such determination may bind the analyst to certain aspects of the analysand's conscious self-experience (e.g., being victimized by others), while cutting off denied and projected aspects of the analysand's inner world, which may initially be expressed only by proxy.

Subsequently, a full intersubjective exploration of the evolving dyadic relationship is undermined.

This artificial selection may reach the analysand's awareness, reducing her or his trust in the analyst's actual caring ("Your empathy is just a technique; who knows how you really feel?"), or contributing to the analysand's self-image of a weak, vulnerable child, with whom one cannot speak openly.

The analyst's repressed or denied affects may find uncontrolled outlets in acting out, or result in an inner experience of distance or alienation.

Let me give an example. A supervisee reports that his analysand constantly blames him for identifying with his wife rather than with him; all attempts to interpret this as a fearful projection are ineffective. Fuller discussion in supervision makes it clear that the analysand has a point: in the countertransference, the analyst experiences his analysand as a bully and the analysand's wife as a victim. This reaction turns out to have sources in the analyst's life, but to be also shaped by the analysand's projective identification. This analysand consciously depreciates his wife, but unconsciously invites empathy toward her much more than toward himself. It gradually becomes clear that the analyst's past interpretations, which implied denial of the analysand's complaints, made the analysand confused and even more suspicious. On the other hand, a judicious acknowledgment of the analysand's perceptions could become a steppingstone to a new understanding of the analysand's marriage: not as the external battlefield he consciously portrays, but as the stage of an inner drama, in which many

of his own dissociated experiences as a battered child are projectively expressed through his wife (Berman 2000b, p. 275). Naturally, such a shift could facilitate a significant development in the analytic relationship as well.

This example raises the issue of self-disclosure (Aron 1996; Bollas 1987; Cooper 1998; Jacobs 1999; Renik 1999). The legitimacy of self-disclosure is related to my point, since I believe that the change in object relations which I strive to facilitate cannot be achieved in a relationship in which the analyst is idealized into a selfless container or a seamless selfobject, lacking separate subjectivity beyond the subjective willingness to be utilized according to the analysand's needs.

Of course, some analysands need such a state for shorter or longer periods, and it should not be disrupted. Ogden (1989) formulated this beautifully in discussing one of his analysands:

> "I said to her . . . that I assumed that my own wishes to be experienced by her as human were a reflection of an aspect of herself, but that she did not at the moment feel she could afford this complicated luxury since she was so fully involved in fighting for her life" (p. 63).

I do advocate, however, taking advantage of any signs of the analysand's interest in the analyst's subjectivity (Aron 1996), as a springboard for a patient encouragement of the process that Winnicott (1971) described as a shift from subjective objects to objective objects (p. 94)—what more contemporary authors may describe as a shift from object relations to subject relations.[3] The analysand's interest in the analyst's subjectivity is a welcome indicator of progress in many analyses. Its recognition as such does not fit in with a strict maintenance of anonymity (Renik 1999). Such a combination may be experienced as inconsistent or even sadistic; attempted anonymity is consistent with an exclusive focus on intrapsychic processes, but not with an interest in intersubjectivity. Our new goals require

[3] The apparent contradiction in terms stems from the fact that Winnicott spoke of the observer coloring the other with his or her own subjectivity, while current usage emphasizes the recognition of the other's subjectivity.

thoughtful exploration of the points at which the analyst's growing openness could facilitate this process of a joint exploration of the evolving intersubjective reality.

Let me add parenthetically that self-disclosures initiated unilaterally when the analysand is not ready for them, or when the analysand interprets them as a sign of the analyst's weakness or loss of control, may, on the other hand, inhibit or block this process (Berman, in press). The idealization of self-disclosure, turning it into a universal technique, is as risky as the idealization of other techniques.

Self-disclosures of complementary identifications ("when the analyst describes his experience as the object" [Bollas 1987, p. 210]) may be particularly difficult for both partners; and yet they can markedly help the analysand in understanding what goes wrong in her or his relationships, and eventually—following analytic working through—in transforming them. Such self-disclosures can be effective, however, only in the context of an experience of strong investment and support, based on concordant identifications. Our technique in this area is still in an experimental stage; a few examples of recent case discussions highlight some of the issues involved.

Jacobs (1999) offered the following example:

> One day, when Ms. K's assault on me was particularly strong and unnerving, I must have responded by looking troubled. She asked me what was wrong. Before I knew what was happening, I found myself sharing some of my feelings with her . . . . I told her that I felt attacked, that she was expressing a great deal of aggression toward me in a concealed way . . . . [p. 173]

Jacobs's evaluation of this unplanned intervention was mixed: Ms. K's immediate insight was striking ("I guess I don't know what I'm doing or how I affect people. What you said just now is what my husband says" [p. 174]), but some years later she told him that his response had frightened and inhibited her.

This example reminds us that at times self-disclosure is unavoidable. When the analysand has already noticed the analyst's reaction, a refusal to verbalize it may be mystifying and insulting. While Jacobs's

specific formulation may have proved too shocking in retrospect, I am convinced that some attempt to put forth what he conveyed to Ms. K was indeed vital. Ideally, fuller exploration of the impact of the intervention shortly after it was made might have reduced its toxic influences and allowed further progress.

Another example was offered by Renik (1999). In his attempt to show his analysand, Anne, that she tended to criticize herself instead of her husband, he used the words "I am confused" (p. 525). Anne noticed that he was being cautious with her, since the issue was not one of confusion but of disagreement, and Renik confirmed this impression. Anne was intrigued by the realization that her analyst had been intimidated by her, and asked her husband "whether he worried about having her approval" (p. 526). Anne's husband told her that he did. The patient then came to realize "that she could inadvertently intimidate other people by communicating her exaggerated sensitivities . . . . She was too ready to assume that the people she cared about would treat her the way her mother did" (p. 527). In retrospect, we can see that, while the content of Renik's initial interpretation was determined by a conscious concordant identification, the words "I am confused" disclosed a complementary identification hidden underneath, which turned out to be particularly fruitful.

Cooper (1998) described an interpretive style combining an interpretation of the analysand's outside relationships (and contemptuous attitudes, in that case) with self-disclosure about the impact of related issues in the consulting room, seemingly drawing upon both complementary and concordant identifications, as follows:

> I find myself in a dilemma. I want to help you understand . . . how you may feel critical at times that you are unaware of . . . . I also know that when I bring it up, you are likely to feel self-critical or criticized by me . . . . [p. 396]

The missing piece of the puzzle, for me, is whether the analysand ever treated the analyst contemptuously, and how such an element could be utilized analytically.

If the joint exploration process is successful, the analysand's growing capacity to empathically perceive the other's subjectivity, while resorting less to denial or projection, will allow more gratifying relationships with others: spouse, children, colleagues, friends. This in turn could reduce experiences of rejection and loneliness, enhancing the analysand's well-being and self-esteem.

IN AND OUT OF THE JOINT COCOON

> To understand everything to the point of doing nothing, rather than to understand enough to do something realistic, is a miscarriage of analysis.
>
> —G. J. Rose (1974, p. 515)

The relative attention to the drama of the analytic relationship itself and to other dramas going on in the analysand's life is itself the topic of dialectical tension and necessary negotiation. The analysand's complex needs may require different balances at different stages, and they also interact with the analyst's needs and opinions. I can see certain risks both in an underutilization of the transference, when the analytic relationship is avoided, at times collusively, and in an overinvolvement with the transference, when the analysand's outside life disappears into the background.

A parallel and related issue is the risk in avoiding the here and now, as in the classical archeological emphasis (which may be experienced as implying that "you are not mad at me, but at your father") and in avoiding the past ("you are not mad at your father, but at me"). Each of these trends, if pursued single-mindedly, may render the analysis too narrow, repetitive, and predictable, reducing its potential to become a transitional space in which all mental content (past and present, reality and fantasy, inner and outer, "here" and "there") can be verbalized and explored freely, without reductionism.

When analysts interpret all associations as expressing the transference, the analysand's subjective experience may be that much of

his or her life is of no interest to the analyst and of no real importance in the analyst's eyes. The analyst may then be seen as narcissistically self-absorbed, as "a mighty omnipresent object" (Balint 1969, p. 169), as a parental figure too self-centered to be curious about the child's life outside. A friend once told me, sarcastically: "I imagine that if I came into my session and said that my mother died yesterday, my analyst would say: 'You appear to experience my mothering of you as deadening.'" Such a tendency may go hand in hand with a lack of interest in historical, social, and cultural realities (including those of ethnicity, gender, war, migration, and so forth) that influence the analysand's life and become registered in his or her unconscious.

Another aspect of "reclusive analysis" is the objection of some analysts to their analysands' wishes to attend group therapy, family therapy, or various workshops. Certainly, serious exploration of the meaning of such wishes is in order (they may also signify an experience of something lacking in the analysis), but at times the combination proves to be productive; just as a well-contemplated decision to pursue one's studies or career elsewhere is at times a real step toward growth, not necessarily motivated by resistance to analysis. We must avoid a situation in which "we offer ourselves to our patients incessantly as objects to cling to, and interpret anything contrary to clinging as resistance . . . ." (Balint 1969, p. 175). Direct or indirect prohibitions regarding the analysand's plans and wishes color analysis in religious hues, and may be experienced as a commandment: "Thou shalt have no other gods before me."

I once heard of a supervisor's advising a candidate never to use in sessions the names of persons in the analysand's life (speaking instead of "your older daughter," "your boss," and so on), in order to emphasize the intrapsychic focus of analytic work. In my experience, the analyst's familiarity with these names, with the personalities of these significant persons (even with their appearances, if the analysand wishes to bring in photographs), as well as with other details of the analysand's daily life, enriches the analysis, and contributes greatly to the analysand's growing experience of the analyst as a trustworthy ally and partner. Analysands who avoid names may

be expressing distrust in the analyst's memory, interest, or investment in them.

Indeed, there could be another explanation: instances of severely traumatized individuals, who are so painfully involved in fighting for their lives that their object relations are severely impoverished. In such cases, it is possible that a longer period of staying inside the (joint) cocoon is crucial, requiring the analyst's tolerance for the analysand's avoidance of the other—that is, avoidance both of outside figures as meaningful others, and of the analyst as an other. This may lead to a purer "mirror transference" of the kind Kohut described, or to a use of the analyst mostly "as a provider of time and of milieu" (Balint 1969, p. 179). For other analysands, such a transient pattern may appear during periods of intense analytic regression, which must be respected.

Still, in my experience, pure "Kohutian" selfobject transferences, in which the analyst as a person is immaterial, are rare; and the more common phenomenon is the noteworthy appearance of such elements (e.g., mirroring needs, idealizations, twinship fantasies) in combination with other transference ingredients, in which the analyst as a separate person is better acknowledged. The latter ingredients are often heterogenous, too, along the spectrum from displaced childhood images ("Freudian transference"), through projections of one's inner reality ("Kleinian transference"), to instances of perceptive, curious recognition of the analyst's personal uniqueness ("intersubjective transference"). This complex admixture allows for various interpretive strategies, and here, naturally, the analyst's theories, personal style, and countertransference play crucial roles.

My point is not to make an absolute value judgement about the advantage of any one theory or strategy, but rather to point to the risks of their single-minded pursuit, and to the need to listen attentively to the significance attributed by the analysand to our choices. Is one analyst's attempt to maintain neutrality experienced by the analysand as thoughtfully respectful or mostly as avoidant and cowardly? Is another analyst's self-disclosure experienced by the analysand predominantly as honest and open or as wild and upsetting? Is

a third analyst's interest in the analysand's marital crisis experienced as empathic or as voyeuristic? And is the latter analyst's attempt to understand the point of view of the analysand's spouse seen as a hurtful indication of betrayal, or as a sincere attempt to help the analysand figure out what went wrong?

A willingness to consider these questions (which often, of course, have more than one answer) may prove more crucial than the analyst's theoretical rationales and conscious intentions in choosing his or her respective interventions. The open exploration of such questions may become vital in maintaining or restoring the value of analysis as a fertile transitional space, in which a mutual—though surely asymmetrical—new partnership can gradually evolve. In such a partnership, the analyst may be subjected to critical scrutiny no less than the analysand.

It is possible that each analytic model, while sensitizing us to certain issues and opening new horizons, also carries with it unique risks—potential blind spots that go unnoticed when analytic discourse becomes too partisan, polemical, and defensive. Fuller attention to the specific risks of each theoretical paradigm and each recommended technique are of great value to the adherents of that particular approach.

The meanings of analytic themes and patterns are dynamic and shifting, and the analyst must be vigilant in order to recognize new challenges at different stages. Today's fresh insight may be tomorrow's cliché and resistance. Maintenance of a sheltered analytic cocoon, which at one point may be crucial to allow undisturbed expression and slow growth, may at another point turn out to have become a rigid defense against living "outside," a protected and dependent relationship that justifies an avoidance of risk-taking in less secure settings. Ideally, the analysand's growing strength should allow movement forward; but the process may be sidetracked, and our attention to this risk is important.

Freud (1914) made each patient promise him "not to take any important decisions affecting his life during the time of his treatment . . . but to postpone all such plans until after his recovery" (p. 153). This was an aspect of the recommended abstinence. It must

be remembered, however, that at that time, according to Freud, most analyses lasted around half a year or a year. Today, the notion of definitive "recovery" may strike us as naive. Moreover, the gradual shift (contrary to the expectations of Rank and others) toward much longer analyses—while understandable in the light of our fuller awareness of the complexity and earlier sources of emotional life, and our more realistic view of the pace of the change process—makes the formula "analyze first, live later" untenable.

During these contemporary longer analyses, life goes on fully, and crucial life choices and commitments are made, even though some of the motives for and implications of them are understood only in retrospect. Ideally, the complexity of life enriches the analytic discourse, while analysis gradually improves life. When I hear of long analyses during which life remains "on hold," however, I become concerned. When the analytic relationship is for many years the only meaningful relationship in the analysand's life, I wonder if the cocoon has become too impenetrable. While it is quite possible that meaningful analytic work may be continuing, has this work become so insular and self-contained that its implications for outside life have become obscure? Did a strong emphasis on the dynamics of the analytic dyad leave the rest of life in shadow? Or did the cozy, familiar territory become an addictive object, a fetish (Renik 1992), or a phobic retreat? Even with all the pain and anxiety involved, a gradual (and hopefully worked-through) termination in such a prolonged analysis may at times introduce fresh air into the analysand's life, and trigger more positive change than the indefinite continuation of the analysis.

A related issue is that of breaks in the analysis. On one hand, one hears of some analysts whose international careers cause constant interruptions in the analyses they conduct, so that continuity and safety can barely be experienced. On the other hand, other analysts are very worried about taking longer vacations, and limit their private lives considerably in light of this concern. Such protectiveness, I fear, may signify a coconstructed, fearfully avoidant atmosphere. Rose (1974) commented: "Now that analysis and training are nearly endless it may be salutary to have periodic suspension of the analytic

life with its passive expectancy, hypertrophy of thought and verbalization, and postponement of action" (p. 515).

Separations may indeed be painful and threatening (and, for deeply regressed patients, almost unbearable), yet some analysands end up making fruitful changes in their lives when their analysts are away. At times, the analyst's capacity to take time off, making the analyst's own needs into a legitimate reality, turns into a variation of "the analyst's act of freedom" (Symington 1983), which ends up freeing the analysand as well.

It is to be hoped that freedom and mobility will have the upper hand in psychoanalysis, and such increased freedom could also be seen as a potential inherent analytic goal. Ogden has articulated this hope in saying:

> A psychoanalyst has the rare opportunity to live a life engaged in a form of work that affords him or her the possibility of entering into a sustained conscious and unconscious dialogue with another person, at a depth that holds the potential for each to free the other in significant ways from the confines of who each has been to that point. [Ogden 2001, p. 10]

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Psychoanalytic Quarterly, LXX, 2001

PSYCHOANALYTIC GOALS: NEW AND OLD PARADOXES

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INTRODUCTION

There is no single or simple way to study the goals of clinical psychoanalysis, given the wide range of perspectives in the field. What kinds of goals are we talking about? Ideal goals? Real goals? Do such goals refer to the process or to the outcome? Are they the goals of the analyst or the patient? According to which theoretical and technical framework are they conceived? Are psychoanalytic goals similar or different from the goals of life itself? And so we could continue.

These questions are interrelated, and each brings other questions into discussion. At bottom, we inevitably find that what is always being debated is a conceptual issue: What is a psychoanalytic treatment? Even though a discussion of ideal models of psychoanalysis may lead to better understanding in numerous areas, I think that it leaves some fundamental questions unresolved. The study that begins with normative models must be complemented by studies that build on the goals of analysis such as they exist in the minds of analyst and patient, in different kinds of analytic treatments, and as can be verified from observation of the results of real analyses.

Some of the difficulties in defining the goals of psychoanalysis stem from the multiplicity of psychoanalytic theories in evidence today, as well as from historical changes (see Sandler and Dreher 1996). Other problems, however, are not specific to particular theoretical approaches, but seem to occur in the field at large, and these will be further discussed below.

SOME HISTORICAL REMARKS

I will begin by considering some of the discussions of approximately thirty years ago (halfway between Freud's time and the present day), whose contents, in my opinion, are still relevant. My focus is particularly on discussions that took place in the River Plate areas of Buenos Aires and Montevideo, which I have chosen for two reasons: first, this is my own psychoanalytic tradition, and second, these discussions have not heretofore been addressed very often in the Anglo-Saxon psychoanalytic literature, due to linguistic differences.

It is well known that psychoanalysis was for Freud a theory and a form of therapy, as well as a method of exploring the human mind. According to him, there is "an inseparable bond between therapy and research" (1927, p. 256), which makes it possible for analysis to obtain its intended result, namely "making conscious what was unconscious, lifting repressions, filling gaps in memory" (1916-1917, p. 435). Later on, Freud wrote that "the business of the analysis is to secure the best possible conditions for the functions of the ego; with that it has discharged its task" (1937, p. 250), and "where id was, there shall ego be" (1933, p. 80).

These ideas, though generally accepted, are not free from controversy. The union of research and therapy has, no doubt, yielded prolific results, but it has not always been accomplished smoothly. One reason is that relative emphasis may be placed on either of the two components. Should exploration of the unconscious be considered primary, and therefore the analyst need not worry about therapeutic aspects of analysis, mere byproducts of the research? Alternatively, perhaps the fact that certain therapeutic changes occur or do not occur should be taken into consideration by patient and analyst in the exploration they both carry out. Thomä and Kächele (1985) have questioned the "indissoluble" nature of the bond that intertwines theory, research, and therapy, arguing that each of these has its own methodological requirements, which are not always coincident or compatible.

Even expressions appearing to be unambiguous have been subject to various interpretations. For example, the statement, "Where

id was, there shall ego be" *("Wo Es war, soll Ich werden"),* was interpreted in a very different manner by Lacan (1966). According to Lacan, psychoanalysis, instead of extending the ego's imaginary boundaries, must allow the patient to recognize his or her radical division as subject *(sujet).*[1]

Wallerstein's 1965 Description of Paradoxes Regarding Psychoanalytic Goals

In his paper, "The Goals of Psychoanalysis: A Survey of Analytic Viewpoints" (1965), Robert Wallerstein made the following observation in relation to the goals of analysis: "I have organized the presentation [of different viewpoints] along three major dimensions, each of them posing an apparent opposition—or complementarity—in emphasis" (p. 768). He elaborated:

> The first seeming paradox is that between goallessness (or desirelessness) as a technical tool marking the proper therapeutic posture of analytic work and the fact that psychoanalysis differentiates itself from all other psychotherapies, analytically oriented or not, by positing the most ambitious and far-reaching goals in terms of the possibilities of fundamental personality reorganization. [p. 749]

The second polarity identified by Wallerstein is the one between outcome goals of analysis (conceptualized in terms of observable life changes) "and the process goals of analytic therapy, conceptualized in metapsychological explanatory terms that posit at least implicitly a theory of therapy, of how analysis brings about change and reaches its outcome goals" (p. 768). (The term *process*

[1] Leavy (1977) remarked that for Lacan, the ego was a distorting organization: "Far from needing strengthening, the ego needs to be overcome" (p. 217). Correlatively, "what seems to be impersonal drive is revealed to be the person himself" (p. 218). According to Lacanian understanding, the English translation of Freud's sentence should be: "I am supposed to come where it was" (Leavy 1996, p. 1277).

can refer either to the interaction between patient and analyst, or to the intrapsychic process that takes place in the patient.) The third oscillation, observed Wallerstein, occurs between "the more limited and the more ambitious, the more pessimistic and the more optimistic view of how much of this sought-for change can actually be accomplished within the limits of human analytic endeavor" (p. 768).

Wallerstein rediscussed this topic in 1992 and 1995. In *The Talking Cures* (1995), he stated his opinion that questions and dilemmas in the field of psychotherapy are often related to the difficulties of identifying underlying "truly empirical questions" (p. 540). Following on Wallerstein's ideas, I will turn now to a summary of the works of authors in the River Plate who were addressing similar issues at the time of the 1965 paper mentioned above.

Contemporaneous Discussions in Buenos Aires and Montevideo

At approximately the time of Wallerstein's 1965 article, in Buenos Aires, José Bleger developed his ideas about psychoanalytic goals, which appeared in his paper, "Criterios de Curación y Objetivos del Psicoanálisis" ("Criteria of Cure and Goals of Psychoanalysis"), published posthumously in 1973 in the Argentinian psychoanalytic journal *Revista de Psicoanálisis,* with discussions by David Liberman and Carlos A. Paz.

Bleger drew a distinction between two kinds of goals in psychoanalysis: curative goals ("the favorable modification of sufferings and/or pathological organizations" (1973, p. 320) and "maieutic" goals (Socrates' term), which pursue the "enrichment of a more complete development, affecting partly or completely the personality" (p. 326). Bleger pointed out that the cure depends on the achievement of maieutic goals (p. 317), even though maieutic effects can appear without cure, and cure without maieutic effects is also possible—for example, in transference cures, displacement of conflicts onto the analyst, and so on (p. 331). Furthermore, Bleger distinguished between clinical goals and technical ones (i.e., the

means used), observing that both may be formulated in technical, clinical, or theoretical terms: "As an example we may cite among the technical goals with clinical formulation: change neurosis into neurosis of transference; with theoretic formulation: 'make the unconscious become conscious'; with technical formulation: 'working through'" (p. 325).

Building on concepts of the Hegel-Marx tradition, Bleger related the maieutic effects of psychoanalysis to processes of "dealienation" and "dialectization" (1973, p. 327). Defenses keep conflicting terms separated, immobilizing them; they must come into contact so that a process of integration can occur, leading to an enrichment of the personality as a whole. "The right procedure is to integrate conscious and unconscious phenomena in a unique dynamic process, ruled by a unique logic: dialectics" (1963, p. 282).

Bleger's distinction between curative and maieutic effects comes close to, but does not exactly match, the distinction proposed by Jones between "therapeutic" and "analytic" goals. According to Bachrach (1983), for Jones (1936), the former term referred to the patient's subjective sense of strength and well-being, and the latter to changes in the patient's comprehension of the past, in symptoms, or in character. For Bleger, maieutic effects are wider, covering aspects of personality enrichment that are not unique to psychoanalysis, but rather are related to potentials inherent in a full human life.

Bleger was interested in "starting from the effects or results of the analysis to deduce the goals, and not starting from a previous formulation, which may be correct or arbitrary, but, more often than not, is normative" (1973, p. 326). He remarked that most psychoanalytic works study psychodynamic aspects, but avoid the degree of change achieved, which in fact is not easy for the analyst to evaluate.

> The truth is that—paradoxically—the conditions of psychoanalysis do not favor the evaluation of the cure, since frequently—in the course of years—we miss the global

> perspective, shutting ourselves away on what we *cannot* modify. This is very much related with the patient's regressive conditions in the transferential relation. [1973, p. 319, italics in original]

Bleger also reviewed systematic investigations and their methodological difficulties. In his opinion, it is important to compare the patient's changed state with his or her state prior to treatment, rather than with an ideal norm. Using Bion's terms, he proposed a distinction between goals that can be achieved with "the neurotic part of the personality" (which can establish discriminations) from those achieved with "the psychotic part of the personality" (which is not able to discriminate due to a lack or distortion in early bonding). Bleger proposed criteria to operationalize the study of such changes throughout treatment, employing clinical indices that may be evaluated quantitatively.

In his discussion of Bleger's ideas, David Liberman (1973) agreed that "the conditions of psychoanalysis do not favor the evaluation of the cure" (p. 343); this leads the analyst to concentrate on what he or she cannot modify, as well as on transference. Liberman was concerned about the evaluation of changes, as was Bleger; this concern led Liberman to "look for indices that will preserve us psychoanalysts from this effect" (pp. 343-344). He added: "I felt always inclined to correlate changes with data coming from communicational indices (whether linguistic or extra-linguistic), taking some of them, which must be intrinsic to the psychoanalytic process, as the point of departure" (p. 344). "In other words," he continued, "I start from the assumption that, in the end, the statements regarding criteria of curing will have to depart from the findings that the patients transmit to us during the productive moments of their analyses" (p. 344). Liberman noted that Bleger had tried to "look for the goals of psychoanalysis inside the patient's production at different moments of the analytic process" (p. 344); and as an example, he cited Bleger's investigations of the "degrees of freedom" or "repertoire of behaviors" displayed by the patient in the transference, linking such changes with transformations that the analysand may

show in his or her life (p. 344). Liberman died before he could fully complete his research projects; his premature death—as well as Bleger's and, some time earlier, Racker's—was a very significant loss to the development of psychoanalytic thought in the River Plate region.

Carlos Paz (1973) was in complete agreement with Bleger's point that, even though therapeutic benefit is a byproduct of the analytic work, the analyst must always have in mind the intention of curing the patient. Paz wrote, "I feel interpreted here by Bleger, in the astonishment I've always felt when others stated that the goal of psychoanalysis is only 'to psychoanalyse,' and that the cure is not a necessary part of such a goal" (p. 345). Paz disagreed with Bleger's distinction between maieutic and curative goals, however, because he believed that every curative goal is also maieutic, and every enrichment of the personality falls within a wide definition of cure.

Paz regretted the analyst's resistance to the verification and systematic evaluation of the results of psychoanalysis, which he believed force it to remain behind other schools of psychotherapy. He suggested that such resistance originates in idealization and the consequent ambivalence and disappointment toward psychoanalysis (p. 347). He argued for the systematic monitoring of patients, and especially of candidates and analysts, asking: "Why has there never been an attempt to study the outcome achieved, and the degree of 'cure' obtained during the candidate's psychoanalytic training? All the requirements for conducting an excellent investigation are there" (p. 346).

Bleger's question "What is cure?" was complemented by two questions from Paz: "With what kind of psychoanalysis?" and "With what kind of psychoanalyst?" (1973, p. 349). These two questions relate to the diversity of technical and theoretical analytic approaches, an issue leading more to a discussion of the goals of the various analytic schools, rather than the goals of psychoanalysis (p. 350). Since analyzability can only be discussed in connection with a concrete patient and a concrete analyst, one must

take into account the particular analyst being looked at.[2] Paz examined the concept of cure in terms of an interaction, in agreement with Bleger: "Curing . . . is the functional result of a whole, or Gestalt, set up by the patient, the analyst, and the relation that holds between them" (Bleger quoted by Paz 1973, pp. 347-348).

The gestaltic conception of the relation between analyst and patient is part of an important and strong tradition in the River Plate. In particular, Baranger and Baranger (1961-1962) applied the concept of *field* (*campo*) to the analytic situation, remarking that at the unconscious level, a shared fantasy exists between patient and analyst, expressing transferential and countertransferential conflicts, including defensive phenomena, where a collusion between patient and analyst may occur. These shared defensive aspects may become bastions or bulwarks *(baluartes)* that remain split, thus leading to the eventual arrest of the analytic process. One of the goals of analysis is to discover and integrate the contents of these defensive aspects, reintegrating them into the analytic field through interpretation, which must take into account the analyst's countertransference (de León 2000).

Coincidences between Wallerstein and the River Plate Analysts

Bleger's, Liberman's, and Paz's conceptual concerns about the goals of psychoanalysis were similar to the problems pointed out by Wallerstein. Coincidence is even greater regarding the need to identify truly empirical data, as Wallerstein called for in his 1995 paper.

[2] Bachrach (1983) expressed a similar idea:

> We recognize that the development of a psychoanalytic process requires the disciplined participation of a psychoanalyst who, by attitude and intervention, becomes an active ingredient in the process . . . . Indeed, the idea of analyzability rests . . . a great deal [on] a model of the mind and related theories of psychopathology and therapy. [pp. 180-181]

Regarding the first polarity (goal-directedness versus goallessness), the texts considered show strong arguments for the existence of therapeutic goals, based on a wide criterion of cure. The issue of goals, and the questions raised about whether they should be formulated in relation to analytic process or analytic outcome, outlined a very interesting and advanced position for the time. Bleger and Paz called for more systematic research on clinical outcome and for further attention to methodological aspects. Also, Bleger and Liberman advocated a search for objective indexes of change that could be observed during analytic sessions, and which would correlate with external changes.

With regard to Wallerstein's third point (the scope of analytic goals), Bleger's work showed the optimism prevailing at the time about the extension of analytic theory and technique to apply to patient populations traditionally considered especially difficult: those with psychoses, antisocial psychopathic personalities, drug addictions, and so on. At the same time, Bleger observed that treatment goals must be formulated individually, according to the needs of each patient: "One patient ends his analysis successfully in the conditions that another one may start his" (1973, p. 328). We must recognize that the investigations proposed by some of these authors were at least twenty years ahead of what could be accomplished with the methodologies in use at that time.[3]

The questions they posed at that time are still valid today: Which kinds of goals, regarding process and outcome, does the analyst really have in mind? What kind of processes in analysis lead to what kind of results in which patients, and with which analysts? How are changes in the analysis and life changes related? How enduring are the changes? A positive aspect of these questions is that their answers do not depend so much on ideal models or meta-

[3] The situation was similar in other geographical areas during that period, as evidenced by the following statement: "Luborsky titled an article in 1969 'Research cannot influence practice' . . . . In 1987 Luborsky wrote a new article: 'Research can *now* influence practice'" (Luborsky et al. 1993, p. 548, italics in original).

psychological assumptions, and so they pave the way for discussion based on clinical evidence and systematic investigation. I will pay special attention to the first of these questions, that is, to the goals such as they are present in the analyst's mind when he or she is at work.

The Evolution of the River Plate Analysts' Ideas

Even though the innovative nature of Bleger's, Liberman's, and Paz's thinking was widely acknowledged in Buenos Aires and Montevideo, their ideas were not completely in line with the evolution of what we might call the mainstream of River Plate psychoanalysis. Three factors contributed to this situation: a change in theoretical influences, the increasing pluralism of theoretical and technical ideas, and changes in practice related to new social, economic, and cultural situations.

The influence of new schools during the 1970s (mainly Lacanian, Bionian, and Winnicottian) had the effect of warning the analyst against an attempt to focus on therapeutic goals in analysis. Nevertheless, this is an instance in which we may find a paradox between a theory's conception and the way it operates in practice. Even though the analyst's objective may be exclusively "psychoanalyzing," clinical material reveals that therapeutic goals appear in the analyst's interpretations and/or in his or her commentaries, with variations according to the analyst's explicit or implicit theories.[4] In groups where Kleinian influences are dominant, some ideas, more or less reformulated locally, frequently operate as therapeutic goals —for example, that the patient should reach the depressive posi-

[4] Joseph (1992) referred to this seeming paradox as follows:

> Although we try to focus on what our patients bring into the session, and their own individual way of operating, at the same time we do keep, at the back of our minds, our own theoretical perspective, which includes some idea of the kind of psychic change we are hoping for in the long term. [p. 238]

tion, internalize aspects that had been projected, repair internal objects, and so forth.

In the same way, analysts influenced by Bion's theories focused their attention on the patient's mental growth, his or her ability to tolerate emotions, and similar changes, even though Bion (1967, 1970) warned against elements that might override the analyst's intuition—even such aspects as memory, desire, or understanding. Winnicott's (1960) work led the analyst to feel that reaching the true self is an important analytic goal. According to Lacan's (1966) formulations, some of the significant factors of treatment are the relationships of the subject to desire, to the symbolic, to the "lack," and to limits.

We must bear in mind that diverse psychoanalytic schools tend to function as ideal or paradigmatic models of understanding (Bernardi 1989). On the other hand, every analyst probably has certain therapeutic objectives that derive from personal beliefs, or even from the analyst's *Weltanschauung*, and these factors may sometimes influence treatment, despite the caution suggested by the theoretical model employed.

Bader (1994) wrote: ". . . while almost all analysts would share Weinshel and Renik's assertion that analysis should always primarily serve therapeutic aims, we still see evidence of confusion over or neglect of these aims in practice" (p. 263). In my opinion, it is possible that in the River Plate region, the reverse situation holds nowadays—i.e., maybe the analyst's therapeutic goals are more evident in clinical practice than in the analyst's explicit theories.

Perhaps, however, the mere fact of theoretical and technical pluralism has been more influential than any single, specific school regarding the conception of the goals of analysis. Today, analysts face

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On one hand, Joseph recommended that "the analyst . . . not be concerned about whether the change he has observed is good or regressive, perverse or hopeful; his only concern is that it is his patient's individual way of keeping his balance at that moment" (p. 238). On the other hand, on reading Joseph's write-ups of clinical material, we find that her interpretations convey a sense of the desired change.

the coexistence of different ideas whose compatibility is not easy to determine (Bernardi 1989, 1992, 1993); furthermore, shared criteria or evidence—necessary to conduct a fruitful debate—are rarely available (Bernardi, in process). This leads to greater caution in the analyst's putting forward interpretations, as was observed in a study about changes in interpretation style in clinical papers presented between the years 1960–1990 in Uruguay (Bernardi et al. 1995).[5]

Conditions of clinical practice have also changed, and analysts today usually practice several forms of psychoanalytic psychotherapy; this variety of modalities probably helps to foster a tendency to assign greater importance to the internal psychic process of the patient as the main aspect in defining a treatment as psychoanalysis. The definition of an analytic process remains far from clear or consensual, however.

NEW PARADOXES REGARDING PROCESS GOALS

Taking into account the above remarks, we might add a fourth paradox to our discussion of the goals of psychoanalysis, complementary to those identified by Wallerstein: the polarity between the importance given to the intrapsychic process in defining what is or is not psychoanalysis, and, at the same time, an increasing multiplicity of definitions assigned to the term *intrapsychic process*. Further-

[5] These observations were coincident with the following comments of Weinshel (1990):

> In the last few decades there have been impressive (albeit gradual and muted) changes in American psychoanalysis in which our claims and expectations have become more realistic, more in accord with our clinical observations, and more modest. Many of those changes also reflect a relativistic rather than an either/or position regarding our theories, techniques, and results. [p. 632]

Weinshel added: "I suggest that such a necessary but also desirable limitation would help us focus more on those relatively familiar 'facts of observation' . . . ." (p. 633).

more, emphasizing the patient's discovery of the unconscious, rather than the characteristics of the treatment setting or of therapeutic interaction, has led to an extension of what may be considered psychoanalysis—an extension to treatments in a variety of settings. This in turn leads to a fifth paradox: such an emphasis, in the context of a broad and imprecise definition of analytic process, tends to enlarge the field of application of psychoanalysis as a theory and therapeutic method; but at the same time, a concern about maintaining the specificity of analysis emerges, as well as about the need to avoid dilution that may result from a broadening of its forms of practice.

So a query about the goals of psychoanalysis implies a query about which goals and which process we consider psychoanalytic. To enhance this discussion, I will present a clinical example, about which a debate could ensue as to whether it should be considered psychoanalysis or psychotherapy.

CLINICAL EXAMPLE

Mr. A

Mr. A is a young adult who initially consulted me two and a half years ago because of severe panic attacks that had not responded to psychopharmacological treatments (alprazolam, clonazepam, SSRIs). In addition, he presented a dysthymic disorder, hypochondriacal fears, and suicidal ideas, which, although not immediately dangerous, carried potential risks for the future.

Mr. A had had two previous attempts at psychoanalytic treatments, one with an analyst and the other with a psychotherapist of analytic orientation, both abandoned because he felt they were not helping him. When he first consulted me, his life was limited mainly to his work, where he could find brief satisfactions, and to conflicts with his family. He had been trying for many years to divorce his wife, but although he had found a new girlfriend, he was unable to formalize a divorce; the idea of separation from his children and his wife made him feel anguished and guilty. He viewed himself

as mentally ill, with no hope of recovery, and believed himself capable of damaging those around him.

At my first contact with Mr. A, I was surprised by the extent of inhibition of his thinking. It was as though his mind could not tolerate any emotional content not directly related to his work or his pessimistic ideas. Despite his intelligence, and despite his potential for insight (of which I was gradually able to catch glimpses), he was not able to take into consideration either his own or others' emotional states at moments of decision making. He could not postpone his actions, leading him to several kinds of impulsive decisions and contradictory moves regarding his future, which then made him feel ashamed and reinforced his pessimistic feelings about himself.

As he calmed and we were gradually able to explore what was happening in his mind, various obsessive mechanisms emerged, especially a painfully self-reproaching attitude, which made him think that others would be better off without him. But he could not relate this to his frequently egocentric attitudes, mixed with unreal promises based on his feelings of guilt. Although he did not meet DSM-IV criteria for a borderline personality disorder, he showed insufficient integration of his self and his object representations, and his defense mechanisms were poorly adequate to cope with his anxiety.

Mr. A's state of deep desperation when he first came to treatment gave way to an intense dependence on and idealization of me. We started working face to face twice weekly, and sometimes three times a week when he was very anguished. After some months, his panic attacks practically disappeared, requiring only the maintenance of small doses of psychotropic medications.

To outline the various modalities employed in this treatment, I will distinguish several stages of the analysis, although these stages to a great extent overlapped. In the face-to-face stage, my interventions were made primarily for support, clarification, or confrontation; they might be said to have been similar to those made in cognitive therapy. For example, when Mr. A insisted that everything was in ruins and there was no future for him, I remarked that he paid attention only to the negative sides of situations, and showed him

other aspects that he was neglecting. I encouraged him to think about consequences before he acted, inviting him to envision a different future, questioning his idea that everything was lost. I tried not to interfere with any of the decisions he made in his life; rather, I focused on the way in which his mind worked and the consequences thereof. He reacted with relief to my interventions, although he confided that once he left my office, he could not keep thinking in the same way. At that moment, the shared fantasy of cure was that I should lend the patient my mind, so that he could have a space in which to think through his problems more calmly.

One day, close to the eighth month of treatment, Mr. A recounted a dream, which he did not do frequently. He remembered a very clear image of holding his own heart in his hands, and the sense that his heart had to be cured, and that he could play an active role in such changes. This coincided with a period in which his panic attacks had practically ceased, and he began to be able to think more about his emotions. Shortly after he related the dream, I suggested that he start using the couch and that we increase the frequency of sessions; he accepted both changes. He then began to come three and occasionally four times a week, a working rhythm I found appropriate both to treatment requirements and to life circumstances.

During the following stage, which lasted more than a year, Mr. A tried several times to resolve his family situation, carrying out a series of oscillating actions that were accompanied by intense anxiety and distress. Despite his contradictory behavior, there were real and positive attempts to establish a different kind of communication with those around him. I was then surprised by the way in which his images of people began to change: while initially, they seemed to have no interior lives and to act in inexplicable ways, his narrative progressively changed such that the same persons appeared to have understandable feelings, reflecting changes in his capacity to establish emotional contact with others.

By the end of the second year of treatment, changes in Mr. A's dysthymic symptoms became noticeable. He started to show signs of hope, although many times his hopefulness was followed by back-

ward movements that made me think of a negative therapeutic reaction (which fortunately was not severe). A fantasy came to light that we could verbalize explicitly—one that appeared more clearly in his actions than in his words: he was incarcerated in a jail, causing others to suffer, punishing himself by depriving himself of practically everything (sometimes he literally forgot to eat). My role was merely that of someone who could soothe his suffering momentarily and help him limit the damages, but who had no possibility of liberating him, since such an action was neither in my hands nor his own.

During this period, we reconstructed some of Mr. A's childhood, and in particular his identification with his father, who he imagined had had similar problems, and with whom he would have liked to have had more emotional contact. He had experienced intensely traumatic situations with his mother, which were probably somehow related to his present-day moments of desperation. This point still remains unexplored.

In considering the different stages an analysis can go through, we might note that in Mr. A's treatment, the largest part of the scene was initially his current conflicts; it was rare that he brought up dreams, childhood memories, or transferential feelings. Using Bleger's line of thinking, we might observe that Mr. A's repertoire of transference actions was of limited range, with changes in his interpersonal relations outside the analysis being more noticeable.

I have the impression that many of the insights Mr. A achieved were brought about by his learning to truly hear what was said by his wife, his new girlfriend, and his children, so that he could begin to relate to them in a different manner. As mentioned, when Mr. A first came to analysis, he lived in a world of shadow plays that lacked subjective density or depth. An early achievement in treatment was the gradual development of his ability to acknowledge the subjectivity of others—i.e., to recognize their desires, their anger, and so forth, and to hear the needs they expressed. He then began to hear observations about himself, such as: "You act tyrannically." "It seems as though your problems are the only ones." "Are you, by any chance, married to your children?" "Why have you started talking like a psy-

choanalyst since you started your treatment?" "Why do you feel such hatred toward us women?" And so on.

After listening to such remarks, Mr. A would come to the analysis devastated and many times outraged; my task was to help him think about what he had heard. This was very hard for him, because he either totally rejected criticism or was crushed by dismay and self-reproach. However, often in silence, he incorporated elements that allowed him to understand himself and others; in the long run, this enriched his relating capacities and gave him a sense of greater security in his own actions. He could feel that others had not been destroyed by him, and therefore his aggressiveness was not so devastating. Similarly, he could defer his transferential conflicts with me: I was still the idealized and loving father who could understand all his emotional states, but who will also probably fail.

In a recent session, Mr. A related an incident that had upset him very much: On the very same day that he had felt overwhelmed by strong criticism from his daughter, he had had to listen to his current girlfriend reproach him for being too absorbed in his own problems and unavailable to her. This made him feel very angry and that everything was lost. I found myself pointing out to him that his girlfriend could also react as a human being and have her own emotional needs. After saying this, I had the strong—and exaggerated—countertransferential feeling that I was siding with the girlfriend in an inappropriate way; maybe I had used a different tone of voice, or maybe something happened mainly in my mind. When the session ended, I was left feeling puzzled by my reaction; it was not clear to me whether I had identified with Mr. A's girlfriend's complaint, or whether I had reacted as a third party in her defense. Nor could I find within myself a personal reason for such a change in attitude. What was clear to me was that, instead of identifying empathically with Mr. A (what Racker would have called "concordant countertransference" (1957, p. 313), I had felt as though I were having a conflictive interaction with him (which might be considered "complementary countertransference," pp. 313-314). I could not clearly understand why this was happening.

In the next session, Mr. A spoke again about the episode with his girlfriend, which he still perceived as very serious and distressing. I could not find any evidence that he had observed a change of attitude in me. Instead, I found it easier to interpret that he felt his rage destroyed the people around him, and that probably his distress came also from feeling that he was capable of destroying everything we were constructing in the session. Although Mr. A had often said that I might become tired of him and send him away, he ascribed this to the incurable nature of his illness, and not to his own attitude toward me; he usually rejected any transference interpretations. This time Mr. A remained silent for a long while, and I had the impression that he had not entirely rejected my words.

Reflecting back on what happened, I believe that when I took the side of Mr. A's girlfriend, I was reacting to a change in the transference relationship that led me to assume, unconsciously, a different role—a complementary, rather than concordant, one. The changes in the patient's attitude toward other people in his life (i.e., recognizing them as persons distinct from him) were probably now being played out with me, and this made me feel more at ease in my relationship with him.

Discussion

Turning now to the goals of my treatment of Mr. A, as well as the relationship of those goals to the methods used and effects achieved, we might first inquire whether the goals of his treatment are psychoanalytic. My answer is affirmative, although I admit that the issue is debatable. If we consider that the modalities of psychoanalysis, psychoanalytic psychotherapy, and supportive psychotherapy are categories that can be strictly differentiated by their technique, strategy, and indications (Kernberg 1999), it may be argued that Mr. A's treatment started out as a supportive psychotherapy, evolved toward a psychoanalytic psychotherapy, and is becoming an analysis, with many clinical moments belonging to "gray areas" in-between, in which "uncertainty is unavoidable" (Kernberg 1999, p. 1083). One might also discuss the appropri-

ateness of such a shift between different modes of treatment (Oremland and Fisher 1987).

If, on the contrary, we depart from a continuum model, in which psychoanalysis and psychotherapy are seen to represent different dimensions or polarities along a continuum, the relevant issue is by which ways or means changes were taking place, and how such changes might be conceptualized psychoanalytically. I will speak from this second perspective, even though I do not find it necessary to contrast the categorical and the dimensional perspectives. The models that distinguish psychoanalysis from psychotherapy may be useful in providing a general orientation, but there are still a great number of clinical situations that are difficult to categorize in one way or the other.[6]

In the case of Mr. A, the transition from a more supportive approach to a more psychoanalytic one was gradual. My initial goal was very general: to help him to cope with his disorders and to effect within himself, as much as possible, those changes that would enable him to improve his mental functioning and the quality of his life. This general goal gave rise to more specific ones. At first, those specific goals (symptomatic relief, for example) dictated that the treatment be of a supportive nature. Later on, the specific goal became the psychoanalytic exploration of his unconscious conflicts.

EXTRAPOLATING FROM MR. A'S TREATMENT: WHAT AND WHICH ARE PSYCHOANALYTIC GOALS IN CLINICAL PRACTICE

The Goals in the Analyst's Mind: Three Types of Goals

I will now examine such specific goals, emphasizing the way they became apparent to me during my sessions with Mr. A. Dif-

[6] It is useful to keep in mind Wallerstein's conception that there is a "spectrum of the psychotherapies, with nodal crystallizations along the three distinctive modalities [psychoanalysis, supportive psychotherapy, and psychoanalytic psychotherapy]" (1995, pp. 158-159).

ferent goals took shape in my mind at different points in Mr. A's treatment. I will refer to three types: (a) clinical goals, (b) metapsychological goals, and (c) exploratory goals.[7]

To begin with (a), clinical goals were predominant in my thoughts at the beginning of treatment. Mr. A needed to relieve his extreme anxiety and desperation, and to straighten out the chaos present in his life and in his mind at that time. Later on, the need to analyze his intense feelings of guilt and ambivalence became evident, and this brought exploratory goals to the foreground. However, when moments of great desperation recurred, when I could see the risk of Mr. A's acting out, or when I suspected a negative therapeutic reaction, I found myself again thinking of goals in clinical macroscopic terms. I also thought periodically about the changes that were taking place and the evolution of treatment. As the treatment progressed, the clinical goals centering around psychopathological phenomena gave way to life goals, oriented toward achievement of a better quality of life.[8]

The perspective of these goals is macroscopic, referring to the patient's global situation. The clinical goals of analysis, as they relate to diagnostic factors, are formulated by the analyst with more clarity than by the patient, and it is not always possible to entirely share them with him or her. Life goals, on the other hand, rest completely in the patient's hands. The task of the analyst is to help the patient become conscious of his or her own goals, in relation to

[7] This classification is related to the three kinds of formulations to which I have previously referred (clinical, theoretical, and technical), which, according to Bleger (1973, pp. 324-325), allow psychoanalytic goals to become explicit.

[8] The distinction I am making here between clinical goals and life goals is only relative, and it bears a relationship to Kogan's (1996) distinction (following Ticho 1972) between "treatment goals" and "life goals" (although the concepts of these authors are not identical). Clinical and life goals are not independent from one another. In the case of Mr. A, the elimination of panic attacks, suicidal ideas, and so on, were clinical goals, but ones that, of course, also affected his life. Conversely, Mr. A's decisions about how and with whom he would live were life goals, but they required, from a clinical point of view, a change in his psychodynamic mechanisms. Gaining more internal freedom to make decisions was a goal of his treatment that could be formulated either in clinical terms or as related to his life goals.

the patient's options and limitations (internal and external, conscious and unconscious), so that the patient has more freedom to make choices.

I do not believe that the analyst's explicit identification of goals in any way compromises analytic work.[9] As a matter of fact, I am more concerned when certain analyses—even training analyses—go on indefinitely, with no clear idea of what changes are sought. I do not believe that there can be a process of real discovery of the patient's unconscious that does not lead to changes in the patient, either internal or external, expected or unexpected, short-term or long-term. The reason that psychoanalysis proposed the hypothesis of the unconscious was precisely because of its capacity to produce life effects.

Moving to (b), metapsychological goals in the treatment of Mr. A, I note in retrospect that there were moments when I found myself thinking about the goals of his treatment in the language of metapsychology. At these moments, Kleinian ideas about the difficulty in repairing damaged internal objects, and about accessing the depressive position, came to my mind. At other times, I remembered Grinberg's (1964) concept of persecutory guilt. Perhaps more frequently, I thought of Bion's (1967) references to mental growth, and I also found myself evaluating Mr. A's changes in terms of his reflective function (Fonagy 1991; Fonagy and Target 1996). Many other concepts went through my mind at other times in the treatment, relating to the superego, the Oedipus complex, narcissism, homosexuality, and castration anxiety, to give but a few examples. Some of Mr. A's decisions about his family life brought to mind my own viewpoints on life, and sometimes I also felt the need to become aware of my countertransference reactions.

[9] Lacan (1966) remarked that the analyst should avoid appearing to be the one who knows in front of the patient. However, if the analyst remains too silent, or if he or she is not explicit about his or her point of view, the analyst may come across as more authoritarian and may generate more dependence than if he or she communicates personal ideas related to the treatment, as Renik has suggested (1993).

Each of these theoretical concepts (as well as the analyst's personal beliefs) tends to bring about a perspective that directs the analysis toward certain goals, and that is why it is appropriate to make such theoretical concepts conscious, so that their influence becomes more manageable.[10] It is advisable that the analyst look for theoretical coherence between these various concepts after analytic sessions —but not during the course of them, lest his or her listening become too rational and conscious. The theoretical concepts evoked may be useful if used in a suspended manner, operating as an open matrix of possibilities of comprehension that may or may not be helpful.

Turning to (c), exploratory goals, we find our focus shifting to the exploration of aspects of the analysis that are capable of bringing about transformation in the patient or in his or her relationship with the analyst. It is easy to identify superficial issues that require exploration; those more profound are the more elusive ones. During each session, the evenly suspended attention of the analyst is focused on certain elements or on remembered pieces of past sessions, with many times the analyst being unable to clearly explain to him- or herself why this is happening. Something that the patient says appears to the analyst to be highlighted, even though its meaning may be difficult to grasp (Nieto and Bernardi 1984). Representations are much more useful to the extent that they can be expressed in the patient's own words; sometimes they are metaphors or parts of a scene that may develop over the course of several sessions.

An example from Mr. A's treatment may help to clarify the above. One day, the patient began his session by saying, "It's hard for me to say this. You must have thought that all this [referring to particular decisions he had made] would improve my life . . . but the collapse continues. And I let myself collapse . . . I have put up a sign saying, 'Man in demolition,' so that some company will come and finish the demolition . . . because things . . . do not shape up . . ."

[10] This influence is greater when the analyst's relationship with his or her theories mirrors unconscious relationships with mentors or rivals that involve remnants of past transference issues (Bernardi and de León 1993; Bernardi and Nieto 1992).

While the pessimistic tone was Mr. A's usual one, what was new was the emergence of the demolition metaphor (until then he had rarely used metaphors). This metaphor sparked a series of questions (Why put up a demolition sign? What does the demolition company mean, and who are they, inside him?), making it possible for us to advance, during subsequent sessions, in the exploration of the active role played by Mr. A in the determination of his suffering. Some time after that session, he said, "Every time I find the key, I change the lock"—showing greater acceptance of his own participation in his difficulties.

As mentioned above, at times, the analyst's listening may become too rational and conscious, too intertwined with the secondary process. At such moments, I find it useful to gain some distance by "pushing the reset button"—switching to a more open listening modality, one that admits more uncertainty and less rational understanding. It is easier for the analyst to place him- or herself in this listening modality with patients who have a strong capacity for self-analysis. But even then, the therapeutic work tends to organize spontaneously around focuses that imply certain goals, changing over time. In Mr. A's treatment, the focus moved from a more general comprehension of himself and others (helpful to him in facing his crisis situation) toward more specific goals; these latter goals included gaining a better understanding of the ambivalence of his feelings and his unconscious mechanisms, and achieving a modification of the unconscious guilt that paralyzed him. These more specific goals, related to the comprehension of unconscious aspects, operated to shift Mr. A's treatment toward psychoanalysis.

Thus far, I have discussed goals related to the process of treatment and goals related to its outcome. I will now consider two specific aspects of the therapeutic process, particularly as manifested in Mr. A's treatment: free association and transference.

Free Association and Transference: Reflections on Mr. A's Treatment

Mr. A's free association was very much restricted by the lack of fluency and permeability of his preconscious processes. I do not

think, however, that such characteristics preclude use of the psychoanalytic method; indeed, Busch (1994) was right when he observed that the psychoanalytic method cannot be defined exclusively by free association:

> The method of free association, rooted in the topographic model, has not been clearly defined in structural terms. Little changed since Freud; the method is geared toward overcoming rather than investigating resistances. Furthermore, it is designed to discourage rather than encourage self-analysis. [p. 381]

I suggested to Mr. A that he pay attention to the inhibition of his thinking, explore his feelings, and modify his conscious tendency to avoid his internal world. Some schools of psychoanalysis (for example, those based on the teachings of Lacan) are very critical of the role that the patient's ego may play in analytic treatment. But even though the ego may be a suspicious ally, not all its functions should be thought of as a "misrecognition" (*méconnaissance,* Lacan 1953, p. 13); in any case, the analyst's ego is of the same nature. The kind of exploration undertaken by Mr. A was actually a means of discovering resistances or bastions that arrest the process of change —the same function aimed for in the use of more classical free association.

Mr. A's transferences should also be considered. Lack of mobility in his transference patterns has been notorious during his treatment; however, slight transferential movements sometimes had great significance for him. He repeatedly put me to the test with his pessimism, while at the same time exhibiting an underlying need for hope. Using the support his treatment provided, he tried to introduce changes in his relationships outside the analysis, while at the same time attempting to maintain absolute control or to disallow such transformations.

The "battlefield" where such psychic changes were defined was, then, of a dichotomous nature. In the here and now of clinical sessions, Mr. A tested the potential for change, which was threatened by oscillations between his omnipotent attempts and his descents

into a destructive form of desperation, and even more deeply by his most obscure tendency toward repetition compulsion. In the second arena of psychic change, that is, his interpersonal relationships, he tried—and succeeded, little by little—to understand others and to better understand himself, achieving distance from his sadomasochistic and narcissistic fantasies, which had at times dominated the scene.

I would like to underline a paradoxical condition that was evident at the beginning of treatment and influenced the way in which I acted. Mr. A was going through a situation that could be considered an "acute crisis," one in which Freud would have believed that "analysis is unusable" (1937, p. 232). But the crisis originated in and was maintained by the patient's internal conflicts, for which analysis would be the best treatment. Consequently, the therapeutic work aimed initially at effecting certain internal changes, which allowed him, in the first place, to better cope with his external situation, where the affective burden was placed.

As an analyst, I would have felt much more secure in my work with Mr. A if he had early on expressed his conflicts in the transference, before trying to solve them outside of the sessions in a frequently premature and contradictory way. Sometimes, both he and I were worried by the emotional cost (i.e., the suffering) that this would entail for his family and for him, although it is also true that Mr. A's emotional interactions with his family had increased in depth and mutual consideration. I also found myself wondering about the limits of changes that could be accomplished in this manner.[11]

[11] Joseph (1992) emphasized the importance of changes that occur in the transferential relationship over other kinds of changes: "I am stressing that the insight that starts from experience within the transference is very different from that which is constructed primarily from assumptions about development or descriptions of behaviour outside" (p. 238). In my belief, Joseph's description does not take into account changes occurring mainly outside the session, but related to analytic work (for example, the development of new insights in the patient's interpersonal relationships). Such changes enrich the experiencing self and consequently lead to enhancement of the global therapeutic process of change.

At this point, I would like to bring up Freud's observation that transference conflicts and basic psychopathological conflicts do not necessary coincide: "A battlefield need not necessarily coincide with one of the enemy's key fortresses. The defence of a hostile capital need not take place just in front of its gates" (1916-1917, pp. 456). Until now, the battles in Mr. A's treatment have taken place in areas of greater affective intensity, and where the need for change has been greatest. The persons around him have played the role of "external fantasy objects"—that is, they represented an indiscriminate mixture of external reality and projections.[12] Through extra-analytic interactions, but sustained by our work during sessions, Mr. A tried to clarify his external and internal worlds, seeking to establish necessary discriminations. In Bleger's terms, we might speak of a "dialectization" (1973, p. 327) of conflicts that were immobilized because of the separations between their elements. For example, Mr. A began to perceive his ambivalence once he could integrate feelings that until then had been split. I do not think it would have been advisable to ask him to open a new war front, one based on transference, while he was still unable to clarify the critical external situation he faced.

UNDERSTANDING DIFFERENT SOURCES OF PSYCHIC CHANGE: A CHALLENGE FOR PSYCHOANALYSIS

Is it appropriate to place treatments like this one in the category of psychoanalysis—given that, although they are based in psycho-

[12] Caper (1992) wrote:

> According to Strachey, the patient in analysis perceives the analyst as what he calls an "external fantasy object"—a phrase that beautifully conveys the fact that what the patient unconsciously sees in the analyst is a mixture of external reality and projected pieces of the patient's internal reality, the two not being clearly distinguished in the patient's mind. [p. 283]

Caper added that "the neurotic's world is full of such external fantasy objects" (p. 283).

analytic theory and use procedures compatible with this theory, they depart to some degree from standard analysis? As previously stated, my answer is affirmative, although I recognize this as a polemic issue. I find it useful to emphasize the unifying characteristics between the fields of psychoanalysis and psychoanalytic psychotherapies, despite differing techniques, because such an emphasis broadens our clinical perspective. Furthermore, we know that "standard analysis" is a relative term, since no analysis can be pure, complete, or definitive.

It is easy to point out the differences in process goals for the different schools of psychoanalysis, or even between psychoanalysis and psychotherapy; the difficulties arise when it comes to pointing out the differences in terms of outcome goals and verifying them in systematic studies. It is also difficult first to identify the active factors that play a real role in the process–outcome relation, and second, to link them with healing factors that are present in life itself. Thus, psychoanalytic means may lead to nonanalytic results (for example, unnecessarily long training analyses may inhibit adult thinking and creativity). On the other hand, psychoanalytic goals (for example, a better comprehension of one's self and others) may be achieved by different means, not only through analysis.

It should be noted that many different kinds of treatments may produce lasting therapeutic effects, and that certain common mechanisms are likely to be operative in all of them, together with specific aims and mechanisms of each individual treatment. We also know that life circumstances, and particularly interpersonal networks, play important roles in the progress and stability of psychic changes. Mr. A was, no doubt, helped by the positive response he received from his family members in his attempts to improve communication; such changes in communication, in turn, made it easier for him to understand and discriminate his emotions.

Are the changes a patient achieves with the help of analysis radically different from those that he or she can accomplish outside analysis through the action of personal conditions and favorable life circumstances? We may recall Freud's observation in this regard: "Let us start from the assumption that what analysis achieves for

neurotics is nothing other than what normal people bring about for themselves without its help" (1937, p. 225). In some cases, life is "good enough" to enable a person to adequately develop his or her personality. In other circumstances, as with Mr. A, the best we can do is to offer a combination of psychoanalysis, psychotherapy, and/or psychopharmacology, and, if possible, to help the patient find the best side of his or her environment that will facilitate the patient's making positive changes. Psychoanalysis is an effective instrument for achieving changes, but not the only instrument.

In addition, I think that psychoanalysis can play another role. Because of the depth of its relationship to the patient, the analytic method is in the best position to promote insights and new hypotheses about general factors that favor health or sickness. The challenge is still how to formulate a comprehensive theory of psychic change that will acknowledge and integrate different factors that may play a role, be they from the field of psychoanalysis and psychotherapy, psychopharmacology, or life in society. This integration of multiple factors is present in the direction taken by psychoanalytic studies of development, and much remains to be done in the therapeutic endeavor, enhancing psychoanalysis's contribution to psychiatry and health sciences.

CONCLUSION

To conclude with a return to the first polarity identified by Wallerstein, we must recognize—as an inevitable fact—the existence in each analyst of different psychoanalytic goals (clinical, theoretical, and explanatory). Since these different goals may influence the analytic process, it is appropriate that the analyst be aware of their presence, enabling him or her to maintain an adequate distance from them, and so to evaluate, develop, modify, or abandon them.

Goals change as time goes by. Perhaps the changing goals of every psychoanalysis can be expressed through general questions, such as: What aspects of him- or herself does the patient need to develop at this moment? What would change for the patient if he or

she had more internal freedom? Such questions, after all, speak to the analysis of resistances.

It is important that we analysts have at our disposal more information about the range and stability of changes that different patients achieve by means of analysis. Our goals cannot differ materially from the results that we actually obtain or that we can obtain; we cannot offer other than what it is possible to achieve.

I think that we tend to undervalue the symptomatic improvement that patients frequently achieve at the beginning of our treatments of them, as well as improvement of their quality of life, while other therapies register and underline these results. Instead, we may perhaps tend to overemphasize small variations in the analytic process, linked to differences of style between the schools, even though such variations may have very little influence on the patient's life outside analysis.

I agree with Bleger and Liberman that, paradoxically, the position of the analyst is not one that permits the best evaluation of the patient's changes. This is why data drawn from sessions need to be complemented by systematic outcome studies, implemented according to different methodologies. The key issue for investigation is the determination of which therapeutic processes lead to which effects in which kinds of patients.

This question takes us in a direction that begs for a more precise definition of the psychoanalytic process. Every psychoanalytic school departs from certain fundamental key clinical intuitions which are the basis for the building of an ideal model of the analytic process; such a model presents the process goals to which patient and analyst should adjust. One way of understanding the "specificity of psychoanalysis" relies on these process models that are characteristic of each psychoanalytic school.

However, these models are less explicit about what is to be done in cases where the patient does not meet the conditions for the kind of treatment proposed by the model, and nowadays, clinical situations of this sort are more and more frequent in current analytic practice. These various models have not succeeded in arriving at a consensus about their areas of comparative validity, i.e., for

which patients and for what reasons it is advisable to prefer one or the other. Nor do they offer an integrated perspective of different extra-analytic factors (social, psychopharmacological, and so on) that may contribute to psychic change. In considering a second meaning of "specificity," we find that it also refers to each patient's specific needs and personal resources, and to the ways psychoanalysis may contribute toward better understanding them and providing more specific, tailor-made treatments. More attentive considerations of these problems will not only increase psychoanalysis's contribution to interdisciplinary approaches in the field of health sciences, but will also help develop more accurate models within our discipline.

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Psychoanalytic Quarterly, LXX, 2001

THE GOALS OF CLINICAL PSYCHOANALYSIS: NOTES ON INTERPRETATION AND PSYCHOLOGICAL DEVELOPMENT

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I would like to begin by making explicit two assumptions on which my discussion rests. The first is that the goal of clinical psychoanalysis is psychological development, and the second is that psychoanalysts try to reach this goal by making interpretations. I realize, of course, that even these assumptions are debatable, but I would like to take them as givens for now, so that I may focus specifically on how interpretations might bring about psychological development. In the process of doing that, I hope to clarify both what I mean by psychological development and what I mean by interpretation.

Interpretations are, of course, not magical utterances, however much patients (and analysts) might wish them to be, or even, at times, believe them to be. They are simply theories or hypotheses about the patient. I will begin, therefore, by considering psychoanalytic theorizing. A discussion of psychoanalytic theorizing is not a discussion of psychoanalytic theory; it is a discussion of how psychoanalytic theories (including those we call interpretations) are arrived at. The point of this is that, if we know how interpretations are arrived at, we will also know something about what their value and function might be in an operational sense.

PSYCHOANALYSIS AND EXPERIMENTAL SCIENCE

I shall start by comparing theory formation in psychoanalysis with theory formation in the experimental sciences. In the experimental

sciences, theories are established when hypotheses are subjected to the test of controlled experiment. Controlled experimentation is the sine qua non of experimental science, and a hypothesis becomes a well-established theory only by being subjected to its rigors. Once established, theories in the experimental sciences may be used to replace experience in future specific instances of the phenomena to which the theories apply. For example, Bernoulli's Principle, which began as a hypothesis about the relationship between the movement of a fluid and the pressure it exerts on adjacent surfaces, has been so fully verified by controlled experiment that engineers now use it to predict very precisely how much lift a certain wing design will produce. Aircraft designers need not, therefore, construct a series of wings and test them by trial and error in order to know how to build a wing with the desired amount of lift.

Psychoanalysis resembles the experimental sciences in that it forms hypotheses, but it differs from them inasmuch as these hypotheses cannot be validated by controlled experiment. Because psychoanalytic theories cannot be confirmed by controlled experiment, they cannot be used to replace direct experience in specific cases, in the way that theories of the experimental sciences, such as Bernoulli's Principle, can. On the contrary, to the degree that the analyst tries to emulate the engineer by attempting to use psychoanalytic theory in place of direct, trial-and-error experience with the patient, he or she falls short of analyzing the patient.

I believe it is common experience in psychoanalysis for the analyst to recognize in the patient's material an instance of some general theory or piece of knowledge that he or she already has—"this is splitting" (or oedipal conflict, or denial, or reaction formation, and so on). But the analyst who fails to move (or to be moved by the patient) beyond what was already encompassed by his or her theories before the encounter with the patient is courting analytic sterility.[1] The analyst cannot simply assume that the clinical problem at hand represents a specific instance of a general law, and apply

[1] In the words of Rickman (1957), "no research without therapy, no therapy without research" (p. 213).

that general law to the specific instance, since the loss of specific, idiosyncratic detail that this would entail would have a disastrous effect on the lifelike-ness of the resulting interpretation. The analyst can arrive at his or her theory—that is, the interpretation—only by patiently absorbing as much as possible of the detail that is unique and specific to the particular clinical experience with one patient.

For this reason, the analyst must maintain a state of highly polished ignorance about what the patient presents, until the analyst's experience of the patient impresses something on him or her. An aeronautical engineer who tried to design an airplane in this way would be a very bad engineer, having to reinvent the Wright Flyer each time, but an analyst who did *not* proceed in this way would be a very bad analyst. The analyst, for practical purposes, must reinvent the wing each time he or she makes an interpretation.

To put it another way, theories in the experimental sciences are established by the construction of controlled experiments, while analytic theories are established by the absorption of uncontrolled experience. The difference in the way in which the two kinds of theories are established reflects fundamental differences in the subject matter they address. Theories in the experimental sciences may be validated by means of controlled experiments because in experimental science, the phenomena being studied may be controlled, and events can be set up in parallel that differ from one another only by one relevant variable. The availability of controlled experimentation allows these theories to be established with a high degree of precision and certainty. Psychoanalysis studies phenomena that cannot be replicated or controlled in any precise way. It is sometimes thought that this is because of the complexity of the phenomena that psychoanalysis studies. While it is true that these phenomena *are* quite complex, the problem is not just one of complexity; it is not the kind of problem that can be solved by greater computer power. The problem lies at a more fundamental level: the events that analysis studies are states of mind, which are never precisely the same from one moment to the next. Moreover, no two individuals can be said to have states of mind that are "the same enough" to

permit the kind of controlled experimentation that would win the respect of experimental scientists. But, most important, the variables that are relevant to states of mind are impossible to control and manipulate for experimental purposes.[2]

Phenomena that can be studied by controlled experiment are of great interest to experimental science, but of little interest to psychoanalysis, while the phenomena that are psychoanalytically interesting cannot be controlled, and are therefore of little interest to experimental science. To treat mental events as though they could be controlled and therefore studied by the methods of experimental science is to treat them as though they were inanimate phenomena of the type studied by physics or chemistry, and this would be to commit something like what philosophers call a category mistake, that is, taking things or facts of one kind as if they belonged to another (Blackburn 1994, p. 58). But the concept of a category mistake implies that the correct category is available to be selected by the investigator. When we see patients treating mental events as though they were the stuff of physics and engineering, subject to manipulation and control, we say they suffer from concrete thinking, which is a thought disorder. We call this a disorder rather than a category mistake because we believe that the correct category—that of mental events, i.e., events that are not concrete or subject to manipulation and control—is not available to people suffering from this disorder. They have not chosen the wrong category from the universe of categories available to them; their universe simply does not contain the correct category.

In *Learning From Experience*, Bion (1962) gave an account of a patient with such a disorder, following which he commented as follows:

[2] Impossible, that is, without destroying the very thing one is trying to observe. In no area of human knowledge are William Blake's lines more true:

> He who bends to himself a joy
> Does the winged life destroy;
> But he who kisses the joy as it flies
> Lives in eternity's sunrise.

> The scientist whose investigations include the stuff of life itself finds himself in a situation that has a parallel in that of the patients I am describing. The breakdown in the patient's equipment for thinking leads to dominance by a mental life in which his universe is populated by inanimate objects. The inability of even the most advanced human beings to make use of their thoughts, because the capacity to think is rudimentary in all of us, means that the field for investigation, all investigation being ultimately scientific, is limited, by human inadequacy, to those phenomena that have the characteristics of the inanimate. We assume that the psychotic limitation is due to an illness: but that that of the scientist is not. Investigation of the assumption illuminates disease on the one hand and scientific method on the other. It appears that our rudimentary equipment for "thinking" thoughts is adequate when the problems are associated with the inanimate, but not when the object for investigation is the phenomenon of life itself. Confronted with the complexities of the human mind the analyst must be circumspect in following even accepted scientific method; its weakness may be closer to the weakness of psychotic thinking than superficial scrutiny would admit. [p. 14]

An investigation of that assumption—that the psychotic's tendency to treat the stuff of life (mental events) as though it were a collection of inanimate physical objects is due to illness, while the scientist's tendency to do the same thing is not—sheds light both on illness and on the scientific method. In this light, the psychotic appears to be a kind of scientific investigator, exploring his or her mind by using conceptual equipment that is, although adequate for the study of the inanimate, inadequate for the study of the animate. And in the same light, the scientist who treats the mind as though it could be adequately described by a theoretical system that had the same formal structure as those found in experimental science appears to be manifesting something like the concrete thinking of the type exhibited by the psychotic patient. Both observations are valid in some important sense, and both would tell us

something we did not previously know—namely that, in Bion's words, "accepted scientific method . . . may be closer to the weakness of psychotic thinking than superficial scrutiny would admit."

One of the ways that clinical psychoanalysis brings about psychological development is by effecting a change in the patient's perspective or attitude about his or her own mind—a new relationship to the mind, if you will. One aspect of this new relationship is that, after a successful analysis, the patient is more able to treat the events occurring in the mind as mental. Psychoanalysis, we might say, opens up or makes available to the patient the category of the mental. One who has this category available is more able to treat one's own mental life as something that is not precise and predictable, and as something that cannot be readily assumed to fall under general laws already known, but instead as something that must be approached *de novo* each time, with a salubrious respect, humility, and naiveté.

From this point of view, the task that faces the patient is the same one that faces the analyst. The pitfalls that the patient must overcome in forming a relationship to his or her own mind—in "theorizing" about his or her mind, if you will—are the same as those that the analyst must overcome when theorizing about the mind in general, and when making an interpretation to a particular patient.

The belief that one should be able to predict, control, and manipulate one's states of mind—that, for example, one should be able to get rid of unwanted pieces of the mind, or transform their nature at will—is a common one, even among patients without manifest thought disorders, many of whom secretly hope to achieve just this result from analysis. But instead of bringing this about, analysis helps them to recognize states of mind as being indeed mental, meaning not subject to prediction, manipulation, or control, but rather subject only to being acknowledged and thought about.

The analyst thus fails to fulfill one of the patient's fondest dreams, and instead confirms what might seem, from the patient's point of view, like one of his or her worst nightmares—a mind out of control, which many patients equate with madness. It is the ana-

lyst's task to show the patient that "going mad" in this way may actually be sane, and that clinging to the kind of sanity the patient hopes for (i.e., to be in control of a predictable mind) may actually be mad. Or rather, it is the analyst's task to introduce the patient to this point of view. This allows the patient to entertain two points of view—from each of which, that which is liberating and sane is from the other constricting and mad. Maintaining communication between these two points of view in the patient's mind is a goal of psychoanalysis that presents great challenges to both analyst and patient.

For the analyst to be able to help the patient achieve this perspective on the contents of his or her mind, the analyst must have it well installed in his or her *own* mind. The analyst must recognize that events that take place in the mind—the analyst's and the patient's—are autonomous. They appear as if of their own volition, and all the analyst can do is observe their appearance, and try to ponder what they are and how they might be connected to other events. This attitude acknowledges the sovereignty of mental events: the mind is subject to mental events, but mental events cannot be subjugated by the mind.[3]

Although clinically, we discover this sovereignty of mental events again and again—and although what is perhaps our most fundamental theory, that of the unconscious, acknowledges it—very often, our theorizing (that is, the way we use our theories) proceeds as though it can be ignored. This happens when we lapse into making "interpretations" intended to control or change the patient's mind, instead of intended merely to inform the patient, who is then left completely free in using the information provided.

Freud's fundamental discovery was not of a series of empirical theories about how the mind works (repression, the Oedipus complex, and so on), but of an attitude toward mental events that recognizes their fundamental autonomy and uncontrollability; this atti-

[3] This is related to Bion's (1970) idea of "thoughts without a thinker": thoughts that are not produced by the mind, but rather the mind forms to deal with the "thoughts"—mental events—with which it is presented.

tude gives one access to information about the mind that no other approach will yield. Valid empirical psychoanalytic theories emerge from the clinical exercise of this attitude toward the mind. Recognizing the sovereign nature of mental events reduces the analyst and patient to the status of mere observers, describers, and ponderers of states of mind that emerge of their own accord in the course of an analysis.

But of course, the situation is considerably more complicated than that. The word *observers* fails to convey how much both working patient and working analyst are immersed in the emotional events they are trying to describe and assess. What happens to patient and analyst in a working analysis is probably better captured by the German word *Erlebnis*, which has no exact English equivalent, but which may perhaps be thought of as *living through*. Mental events of the type analysis is concerned with not only cannot be controlled in the way physical events can be; they cannot even be observed in the dispassionate way physical events may be. They can only be lived through.

An approach to mental events (whether on the part of the patient or the analyst) that treats them as inanimate is an attempt to attain the same cool objectivity and the same ability to predict and manipulate them that accepted scientific method has given us in regard to physical events. This desire is an expression of a need for a sense of security and protection against the turmoil and turbulence that are unavoidable when in contact with someone's mind (even one's own).

IS PSYCHOANALYSIS AN ART FORM?

The thrust of my argument so far is that we cannot regard psychoanalysis as a science in the established sense of the word, but must view it as a science in a class by itself. But might we not go even further and say it is not a science at all, but something else, such as a form of art? The similarities between psychoanalysis and art are indeed striking. An analysis, like a work of art, is produced uniquely in each instance; the analyst, like the artist, solves the

problems that the production of the work engenders as he or she goes along, and, also like the artist, does not even really know what the problems are before the work is already in progress. Moreover, neither an analysis nor a work of art is produced by the application of general, preexisting theories (psychoanalytic or aesthetic). They are produced by the analyst or artist responding intuitively to the materials at hand. Finally, both the working analyst and the working artist, such as a poet, use the music of language and its power to evoke images and emotion to convey an experience, and to illuminate hitherto unseen, complex, and subtle relationships between different aspects of experience. And poetry and psychoanalysis may both alter one's picture of oneself and of the world.

But there are also crucial differences between psychoanalysis and art. Analysis conveys experiences that foster psychological development. What I mean by this is that, while art provides aesthetic experience, analysis increases one's capacity for aesthetic experience, that is, one's capacity to feel in general, and one's capacity to feel like oneself in particular.[4] This increase in the capacity to bear emotional (aesthetic) experience is purchased at the price of security. The security that must be given up in exchange is precisely the security obtained by treating mental events as though they can be manipulated and controlled, and as though one may insulate oneself from their impact. An increase in the capacity to bear experience at the expense of security is a second way of formulating the goal of clinical psychoanalysis.

PSYCHOANALYTIC TECHNIQUE

> It may be that this first portion of our psychological study of dreams will leave us with a sense of dissatisfaction. But we can console ourselves with the thought that we have been obliged to build our way out into the dark. [Freud 1900, p. 549]

[4] To be fair, great works of art have this effect as well, so the distinction I am making between psychoanalysis and creative art in this respect is not absolute.

Psychoanalytic technique consists of the analyst's allowing the patient's unconscious to have an impact on his or her unconscious, and of the analyst's tolerance of the conscious emotional experience that evolves from this, so that the analyst may use it to build a way out into the dark of the immediate, live interaction between analyst and patient, and thence back into the patient's unconscious. For this to happen, the analyst must be in the dark. Too much light (or too little dark) is a sign that omniscience and control have replaced learning in the analyst's mind. The reason that a carefully preserved ignorance and naiveté is so essential to the practice of a therapeutic analysis is that it is a way of wresting the capacity to learn from the grip of omniscience—i.e., what is falsely felt to be known. Analytic expertise (in any practical and useful sense of the term) does not consist of a body of knowledge, but of the capacity to remain ignorant long enough to have new experiences of the patient, experiences from which the analyst may learn.

Analysis depends on surprise—on the discovery of what has not been known beforehand, and perhaps not even suspected. This discovery depends on the capacity to preserve the mystery of a novel experience long enough to contemplate it, and to be surprised by what one has found. The rescue of mystery and surprise from the "knowledge" that functions to destroy them is a third way of formulating the goal of clinical psychoanalysis.

But mystery, once restored, tends always to be eroded away once more. What has newly been learned comes quickly to be "known" in a way that allows it to act as a defense against further mysteries, surprises, and learning. The capacity to be mystified must therefore be regained over and over in an analysis. This dialectic of emergence from false knowledge (omniscience) into mystery, of falling back again, and of emerging again, over and over, is the dialectic of psychoanalytic development.

The replacement of omniscience by a sense of mystery in an analysis—the restoration of a healthy ignorance—means recognizing that we do not control the object's mind, any more than we can control our own unconscious minds. This is the same as recognizing the essential separateness of one's object from oneself. Anything

the analyst learns about the patient that does not also teach him or her that the patient is a separate person is not true knowledge about the patient, but merely a defense against the anxiety that the essential separateness and uncontrollability of the patient's mind arouse in the analyst (see Caper 1994).

Even if we agree that psychoanalysis is not an art form, but a peculiar science, there remains the fact that interpretations resemble more closely the products of the artist's intuitive response to artistic materials than scientific hypotheses that can be verified by controlled experimentation. What assurance do we have, then, that an interpretation is likely to be valid? How do we know that it is not simply an artistic creation—an aesthetically competent but otherwise arbitrary communication? The answer I would give is that psychoanalysis has developed a unique clinical instrument: the state of mind in which the analyst resides while working well. This state of mind is characterized by a sense of mystery, awareness of a lack of control over mental events, and a sense that the patient is mentally separate from the analyst. The observations made in an analysis while the analyst is in this state of mind may be taken as valid, in the same way that images produced by an astronomical telescope may be taken as valid when the telescope's optics are known to be in good order.

Among the signs that the analyst's mind is working well as an analytic instrument is, as noted, the analyst's ability to discover unique aspects of the experience he or she is living through with the patient. Of equal importance as a sign that the analyst is working well is his or her ability to refrain from using what is discovered for any purpose other than conveying information to the patient. This means that the analyst must listen without omniscience (the need to have theoretical preconceptions about the patient, or to "know"), and without desire (the need to fix the patient, as opposed to merely conveying information about the patient's self to him or her). But omniscience and desire are constantly being stimulated in the working analyst. Much of the work of analysis consists of self-analysis of the omniscience and the desires that the analytic process stimulates in the analyst. The product of this analysis is an interpretation

that—if the self-analysis has been successful—is spoken solely to convey information to the patient, not as an attempt to control or otherwise reduce the patient to the status of the inanimate.

An interpretation given by an analyst whose mind is working correctly as a psychoanalytic instrument is not an attempt to cure the patient. Instead, it is the product of the self-analysis of the analyst's desire to cure the patient, or of any other desires or fears the analyst has in connection with the patient (see Caper 1992). This becomes clearer if we consider that "curing the patient" is usually an attempt to kill something in the patient's mind, or to trim his or her mind to fit the analyst's preconception of what the patient should be like, rather than to do what analysis can do uniquely well: to improve the patient's capacity to be in contact with and to tolerate his or her mind as it is, so that the patient may develop independently.

To put this another way, the working analyst must live through an emotional experience with the patient, then think about that experience untendentiously, and then convey what the analyst has gleaned from this to the patient in a way that is free from suggestion, coercion, or any hint that it is anything other than how things are *in the analyst's opinion.* Or rather, the analyst must *try* to do this. One of the paradoxes of analysis is that the analytic situation could hardly be better calculated to make it impossible for the analyst to maintain an objective, nontendentious stance. But it is precisely this fact that makes the analysis alive. The ways in which the analyst fails—i.e., gets pulled out of the position of listening without preconceptions and speaking only to convey information to the patient—allow the analyst, if he or she is able to think about them, to be in contact with the immediate experience being lived through with the patient. Analysts need to have a great deal of the experience of being pulled away from the analytic attitude by emotional forces originating in themselves and/or the patient, and of being able to regain that attitude, before they can have the courage and the conviction necessary to allow themselves to be pulled out of the analytic attitude while still feeling that they will be able regularly to return to it later.

To summarize this point, I am proposing that the criterion for ascertaining the validity of an interpretation—in the absence of any possibility for controlled experimentation—is that the interpretation be arrived at while the interpreter (who may, in fact, be either patient or analyst) is in a state of mind in which he or she is not attempting to control the object (either another's mind, or his or her own mind), and that preserves a healthy ignorance about the matter at hand. Preservation of ignorance is not the same as simply being ignorant or mystified; it is a type of knowledge: the knowledge that one is in the presence of something unknown.

But as noted above, the analytic relationship could scarcely be better designed to stir up the analyst's anxieties and desires for the patient, thereby creating the need to control the patient. A psychoanalytically productive state of mind can only be achieved through experiencing and working through this need. To the degree that this has been done, the resulting analytic perspective is likely to yield valid interpretations. In all of this, I am making the assumption that we can see the truth if nothing is pulling us away from it, and that the ways in which we find ourselves getting pulled away from it constitute an important part of the truth we need to see in an analysis.

THE GOALS OF CLINICAL PSYCHOANALYSIS

Bion (1965) suggested that the product of the analyst's work may be considered either

> . . . the analyst's verbalization of his experience in the session, or the emotional state induced in his patient . . . . *Since psycho-analysts do not aim to run the patient's life but to enable him to run it according to his lights and therefore to know what his lights are, [the analyst's communications] either in the form of interpretation or scientific paper should represent [only] the psychoanalyst's verbal representation of an emotional experience . . . . [the analyst's communication] must be limited so*

> *that it expresses truth without any implication other than the implication that it is true in the analyst's opinion.* How is truth to be a criterion [for an interpretation]? To what has it to be true and how shall we decide whether it is or not . . . . Falling back on analytic experience for a clue . . . in practice the problem arises with . . . personalities in whom the super-ego appears to be developmentally prior to the ego and to deny development and existence itself to the ego. The usurpation by the super-ego of the position that should be occupied by the ego involves imperfect development of the reality principle, exaltation of a "moral" outlook and lack of respect for the truth. The result is starvation of the psyche and stunted growth. I shall regard this statement as an axiom that resolves more difficulties than it creates. [pp. 37-38, italics added]

The product of the analyst's work may be the analyst's verbalization of his or her experience in the session, or it may be the emotional state induced in the patient. But whichever it is, it is psychoanalytic (as opposed to being propagandistic) only if the patient is free to choose how to use the analyst's communication. The analyst should add to the patient's experience, but the type of experience the analyst adds should be one that helps the patient "run his life according to his own lights, by helping him see what his lights are," to paraphrase Bion. To avoid appearing omniscient, thereby feeding the patient's belief in omniscience, the analyst's communication should carry no other implication than that it is the truth *in the analyst's opinion.*

This healthy modesty has two consequences. First, it undermines the patient's belief that analysis will solve his or her problems, and second, it leaves the patient free to solve those problems, that is, to live his or her own life. Only in this way does the analyst leave the patient at liberty to choose how he or she will use the product of the analyst's work, and only in this way can the analyst avoid becoming what Bion called a "superego that usurps the position of the patient's ego."

Therefore, one criterion for determining that the analyst's communication acts in the service of helping the patient "find

his lights" is that it not be superegoistic. This suggests that the analyst's clinical work is not fundamentally a scientific or aesthetic activity, but an ethical one: its goal is the broadening of the patient's experience, and especially the patient's experience of him- or herself, in a way that leaves the patient free to use that experience as he or she sees fit. The analyst respects the patient's autonomy enough to refrain from "curing" the patient, and in this way, resists the temptation to become an archaic superego that usurps the position of the patient's ego.

As I am using the term, the *ego* is the part of the personality that is concerned with perception, memory, judgments about reality, assessment of meaning, thinking, feeling, and thinking about feeling. In classical terms, it is that part of the id that has been modified by contact with reality (internal and external). What this means in contemporary terms is that the ego develops by contact with reality, and that contact with reality means acknowledging its existence as something separate from itself, whether in the form of another mind separate from one's own, or of an autonomous unconscious (separate from one's consciousness). An intrinsic part of this is the acknowledgment that one does not have control over one's objects or one's internal reality.

The archaic superego,[5] however, is concerned precisely with control and moralistic judgment. It is a part of the id that has been modified not by contact with a reality acknowledged as separate from the self, but by a process that is in many ways the opposite of this—namely, narcissistic identification, or a type of identification that confuses self and object. Freud (1933) referred to this confusion when he wrote that

> . . . there is no doubt that, when the super-ego was first instituted, in equipping that agency use was made of a

[5] A discussion of the mature superego is beyond the scope of this paper, but it will perhaps suffice to say here that it is realistic—that is, its function, like that of the superego, is based on contact with reality. It therefore bases its judgments on real consequences (intra- and extrapsychic), rather than on archaic or omnipotent fantasies, as the archaic superego does. It follows from this that the mature superego does not differ much at all from the mature ego.

> piece of the child's aggressiveness towards his parents . . . and for that reason the severity of the super-ego need not simply correspond to the strictness of the upbringing. [p. 109]

Narcissistic identification is associated with a feeling of being at one with one's objects ("I am the object"), and it produces a sense of control over them. It occurs for many reasons, but one of them is to provide a defense against the anxieties associated with knowing that one is no more than who one is.

In sum, the ego is concerned with perception, memory, judgment, assessment of meaning, thinking, feeling and thinking about feeling, while the archaic superego is concerned with control. If the ego is a part of the id that has been modified by contact with reality, the archaic superego is a part of the id that has been modified by narcissistic identification (as a defense against contact with reality and the resulting insecurity associated with knowing who one is and is not). The ego develops via a kind of learning that, as I have argued, requires one to acknowledge one's lack of control over and separateness from one's object. But the sense of control and nonseparateness that must be thereby relinquished undermines the very foundation of the archaic superego, namely, narcissistic identification. The ego can grow (think and learn) only at the expense of the archaic superego, and vice versa.

An unavoidable conflict exists, therefore, between the ego and the archaic superego. A fourth way of formulating the goal of clinical psychoanalysis would be to say that analysis fosters the growth of the ego, the part of the personality in distinct contact with reality, and which can think, feel, and form judgments based on thinking—at the expense of the archaic superego, that part of the personality based on a confusion between self and object, which replaces thinking with an identification with an idealized object that, among other things, "knows" so much that it need not think or learn.[6]

[6] This view of the archaic superego has obvious connections with Lacan's (1988) concept of *sujet supposé savoir*.

I have described four perspectives on the goal of clinical psychoanalysis: (1) to increase the patient's capacity to experience his or her mental life as mental, meaning not subject to control, manipulation, or precise prediction; (2) to increase the patient's capacity for aesthetic experience—or, in other words, the capacity to feel and to think about what he or she feels; (3) to rescue the patient's capacity for surprise, and for seeing new things as new, from a false knowledge that obstructs new experience (omniscience); and (4) to foster the growth of the patient's ego, and specifically, its ability to think, feel, and form judgments based on experience, and to protect it from the archaic superego, which does not think, feel, or judge based on experience, but instead simply "knows."

I call these *perspectives* on a single goal of clinical psychoanalysis, rather than four separate goals, because they are related as different aspects of the same thing. A capacity to acknowledge the autonomy of one's mental life is clearly related to the capacity to feel what is actually in one's mind (as opposed to what one wishes to be there), and both are connected to the capacity to be surprised by what is there, and to the capacity to feel and to think about one's feelings, even in the face of what one is supposed to "know" about oneself.

While these are four perspectives on the same thing, they only point toward, rather than define, precisely what that thing is. Perhaps, as a practical guide to identifying the goals of clinical psychoanalysis, it is worth recalling Charcot's words: "*La Theorie c'est bon, mais ce n'empeche pas d'exister*" (theories are good, but they do not preclude things from being what they are).

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Psychoanalytic Quarterly, LXX, 2001

ME AND MAX: A MISALLIANCE OF GOALS

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INTRODUCTION

Max

One of the burned-in memories of my lengthy life as an analytic candidate is of an event that took place in a case conference chaired by Maxwell Gitelson. Gitelson was a sort of crotchety and imposing man who was fairly humorless and could easily and honestly be characterized as opinionated. This particular moment of meaning of mine occurred when, to the best of my memory, a student said something or other about either his and/or the patient's hope (and goal) that the patient would soon feel better. Gitelson proclaimed (rather than offered) his opinion that psychoanalysis was not meant to make people feel better or to relieve symptoms; rather, the goal of analysis was to allow patients to better understand themselves. Relief of symptoms was a sort of chance byproduct of such understanding, but it was definitely *not* the goal of analysis. Nor should any psychoanalyst pursue that essentially secondary effort.

My silent reaction to Gitelson's "Bah, Humbug" appraisal of symptom relief was my own "Bah, Humbug," since I was convinced that almost everyone I knew in analysis wanted to feel better, and if self-understanding was what had to be swallowed, then that medicine could and would be endured, but it was hardly the goal that I personally would rank as number one. It seemed clear that one person's goal was just not properly or necessarily made for another. Rather than one size fitting all, it seemed that the goals of the pa-

tients and the goals of the analysts, and the goals of the field of psychoanalysis, might well lie in separate areas of concern. They need not be in opposition, but they surely are not and cannot be reduced to identical significance and importance.

The combination of my desire to be a good student, plus my near-total intimidation by Gitelson, allowed me over time to adopt his singular goal as mine. I periodically and often surprisingly found myself saying and even believing that the goal of analysis was self-understanding, especially when my patients would point out that I was not helping much with their psychic distress. I could readily recognize the comfort that this adopted stance offered, inasmuch as it allowed me to cast myself as someone in pursuit of this more noble effort of a variation of "truth," rather than settling for the lesser metal of mere comfort and relief. Also, the analyst's view of symptom relief as a happy though accidental companion of analysis enables the analyst to achieve a feeling of personal pleasure without the encumbrance of satisfying someone else's (the patient's) wishes. In this way, I found myself allied with what I imagined were the more lofty aims of the field, rather than joined with those of the individual patient: selfish but safe.

Sooner or later, one must surely realize that concern over the proper goals for what one achieves or what discipline one espouses is basically a moral issue. The pursuit of doing well readily collapses into doing the right thing, and so a conflict occurs, at times, between making the patient feel better versus, say, satisfying Freud's axiom of "where id was, there shall ego be" (1933, p. 80). Unless the satisfaction of the axiom yields an equal degree of contentment for the patient, one cannot reduce the latter to a byproduct of the former. The relief of symptoms and the happiness of the patient become the goals, according to this moral stance, and that of self-understanding sort of trots alongside. One could, of course, eliminate the problem if these two or three goals always emerged and then merged together, but we are regularly haunted by analyzed patients who claim that they feel no better, alongside happy ones who seem quite psychologically opaque. My loyalty to Gitelson was severely tried.

Charles

My next memory, a bit less severely etched, comes from another teacher, Charles Kligerman, who was anything but crotchety but probably equally opinionated. He would regularly say that analyzed people are just different from nonanalyzed ones. He would also pronounce this with a certain sense of the former belonging to a very exclusive club, and with the secondary message that one would do well to limit one's acquaintances, friends, and certainly spouses to that membership. Putting aside this seductive elitism, Kligerman's position made it clear that analysis did something that was lasting and was more than just freeing someone from psychic pain, since that latter quality would never by itself lead to this exclusive club admittance. Therefore, the goal of analysis involved some significant alteration in the patient, one that went beyond symptom relief, and perhaps even beyond that ephemeral state of understanding. It made one a different person—and at least to some, a better one as well.

Somehow, the goals were beginning to become better demarcated, although perhaps not in the way Max and I might have wished for. They were not singular in that they had to satisfy a multiplicity of needs. But perhaps the most striking alteration or addition to this original and somewhat encapsulated version of goals offered by my mentor was that the change was not limited to the patient, but seemed to extend to the analyst as well. That is to say that the practitioners of analysis are different, both because of their personal analyses, and because they practice the somewhat noble enterprise of turning out special people. To combine the views of my two mentors might well lead to one being overwhelmed by elitism, as well as by the altitude of this rarified atmosphere.

The challenge that presented itself to me was that of reconciling or somehow unifying what seemed to be a threefold set of goals: that of self-understanding, of relief of discomfort, and of a lasting or relatively permanent change or enhancement of value. Each of these three seemed essential and each seemed connected to the others. Thus, the focus upon one or another should contain

some element that would lead to the others. Without in any way denying the multitude of subsidiary benefits of treatment, which could range from a happier marriage to a more fulfilling sex life, these three endpoints should be all-encompassing. So now to examining each in turn.

SELF-UNDERSTANDING

The dominance of the ego and the accumulation of insight into one's unconscious, taken together, are assumed to lead to a body of knowledge that enables one to comprehend one's self differently. This difference may take the form of a narrative of one's history, or on other occasions, might narrow in on a retelling of a more focused event, such as a particular moment of trauma. Patients surely differ in the manner in which they reflect back upon their analyses. No matter how much one insists upon analysis being an activity in which the participants engage in narration (Schafer 1992), or one of the recovery of memory (Fonagy 1999), these are more properly seen as one or another *form* of the procedure, rather than as the fundamental goal. There can be little doubt that some patients prefer telling their life stories, some wish to concentrate on the here and now with little reference to personal history, and some seem peculiarly devoted to elaborate Proustian reminiscence. That such a personal preference is regularly seen to match the preference of the analyst alerts us to the value of looking for this particular form of the goal of analysis as sometimes lying outside the essence of the process.

Consider the following patient: A young professional man entered analysis with the clearly defined and stated aim of getting married. He claimed to have had a host of involvements with marriageable women, but not to have done much more than living with one for a few months. That particular experience was characterized by emotions ranging from discontent to disgust, with not a hint of a wish for this couple of roommates to remain together. Yet he insisted that he longed for marriage to the right woman, and he hoped that analysis would realize that possibility.

I shall not detail the conduct of this analysis, save to say that somewhere along the line, he did marry, but long after he had dropped that issue as crucial to his life as an analysand. What memories he did recover seemed minimal, and as Alexander long ago suggested (1940, p. 146), these were more confirmatory than revealing. I believe that the patient and I would be hard pressed to recount a detailed new version of his life as well. Indeed, most of his analysis had to do with his father, and concentrated not surprisingly on the minutiae of the transference reflective of this.

Toward the end of his analysis, there was no doubt that the patient saw himself differently; thereafter, almost everything problematic in his life, from a telephone call to his mother, to the loss of money on an apparently promising stock, led to his subjecting himself to self-scrutiny. His psychic life was of two parts: the first was composed of a relative ease of events and relationships with others, the second of an intense self-reflection upon anything that represented conflict or difficulty. (It should not be necessary to underscore that this division is not true of everyone, inasmuch as many of us are frequently carefree, whereas others seem never to be free of concern and worry.) My patient regularly reviewed and reflected upon the puzzle of everyday life, and he did so in a manner and with a method that was clearly a miniaturized version of his analytic experience.

I think it safe to conclude that the self-understanding which was facilitated in this analysis was a product of the personalities of both of us, and that it could be characterized by using a variety of theoretical lexicons. That I spoke a certain language, which my patient over time made his own, should not be seen as mere brainwashing. His way of thinking about himself during the analysis would often begin with his announcing: "I know that you would say . . . . " I took this both as a form of identification and of differentiation. Indeed, one might well say that my patient began by understanding me, and then moved on to an understanding of himself. I take this feature as essential—i.e., the gradual dissolution of the transference should over time reveal the analyst to the patient.

The greatest obstacle to this hoped-for sequence is often the unwitting or unnecessary self-revelation of the analyst. The discovery of what the world, any world, is like may follow the guidelines or map of another, but is not to be equated with a carbon copy of the other. This analysis ended with each of us changing and yet remaining quite different persons. The outstanding feature for the patient was his newfound capacity to puzzle over his life's ups and downs, i.e., his personal form of self-reflection.

RELIEF OF SYMPTOMS

Another patient reported to me after a year of analysis that she felt much better in comparison to how she had felt a year earlier, but could in no way say just what her analysis had accomplished. This feature of feeling better is a happy companion to psychotherapy, psychopharmacology, and even the ordinary occurrences of everyday life. Everything from a good night's sleep to winning the lottery can be capable of eliciting this sort of self-report of contentment, but only a few persons seem able to sustain this desired endpoint. No doubt, a certain amount of ongoing maintenance in the form of the above-mentioned self-analytic or self-reflective work is essential for the sustaining of this feeling of being better, but that seems not to be the whole story. Just as I might give credit to one or more of my teachers who studied and wrote about post-termination self-analysis (Robbins and Schlessinger 1983), I owe my debt for knowledge about the more lasting effect of analytic improvement to Kohut.

Kohut was often at odds with those who emphasized the role of self-analysis following one's work in a therapeutic analysis. He felt that the establishment of meaningful selfobject relationships, or the opening of empathic connections between persons, was the foundation of analytic cure (Kohut 1984). Therefore, one need not be concerned with self-analytic work, save for moments of disruptive breaks in these empathic connections. The availability and deployment of selfobjects were the essentials for navigating through life, and psychic health was equivalent to this dual capacity. Thus, Kohut looked

upon self-analysis as evidence more of an incomplete analysis than of the ongoing maintenance of analytic benefits. If one had established a firm and lasting sense of self-cohesion, then there need be few occasions for the self-reflective work necessary to repair an empathic disruption. Or so the story goes.

My own ecumenical bent was to join the two issues of self-cohesion and self-reflection, inasmuch as I remained ever short of perfection, and given that most of my patients were wedded to regular self-reflection. No one in my caseload had achieved the sought-for ideal state of persistent selfobject sustenance alone. Although this was a desirable point of personal achievement, such an ideal state was equally often elusive. For some patients, it was overwhelmingly elusive, while for others, self-reflection was an equal rarity. Once again, the mix of goals among my patients reflected the complexity of an interaction between two complex entities: the patient and the analyst, along with these two elements—self-cohesion and self-reflection—of supposed cure. The patient who reported feeling better after a year of therapy had no doubt made the necessary connection to allow for a firm sense of self-solidity with her selfobjects. But would it last?

THE LASTING VALUE

The lasting value of feeling better is the product of an underlying change which is attributable to something called *psychic structure*. Although this may be described and developed in a variety of ways, it underscores a way of talking about one's stability over time. This stability may be thought of as an enabler of both self-reflection and the relief of symptoms. Although it may seem intangible and even tautological, it is the theoretical convenience that we employ to characterize the improvement associated with analytic goals.

This gain or growth in psychic structure is often claimed to be equivalent to the ordinary processes of normal development. More properly, however, it may be thought of as analogous to development. Normal persons are not analyzed persons. Achieving a solid

sense of connection with one's selfobjects, like gaining insight into the contents of one's unconscious, cannot be readily equated with the process of a normal child's development. For the former—i.e., achieving enduring connections—there is an ease of selfobject relationships in development that is rarely the case in analyzed adults, who are at best able to cautiously and carefully choose particular others to whom they can connect. For the latter, that of knowing one's unconscious, it is a failure of repression that reveals the unconscious to an adult who is most successful if his or her drives are neutralized or sublimated. Such non-neurotics claim not insight, but ignorance.

But any psychoanalytic theory can be used to distinguish and describe the analyzed person as different from the unanalyzed but non-neurotic one, and all such theories ultimately point to a crucial distinction of some sort. In a nutshell, analysis *adds* something to the person who is analyzed, and this addition, no matter how one speaks of it, becomes a lasting and distinguishing characteristic. Psychic structure is the catchword for what is added. It is by way of this concept that one is able to consider the significance of the time axis in the achievements of analysis. Change that lasts, or enduring function, reflects this underlying something that offers stability and sustenance. Now perhaps we are able to weld together and join the three measures of analytic accomplishment.

ALWAYS ANALYZING

My now-married patient described earlier, who is presently gripped by the sheer curiosity of living, once complained to me that he was jealous of those friends and acquaintances who seemed to be happy—or even unhappy—but who had no concern as to the origins of their psychic status. Indeed, they seemed to move through life without really thinking about it. In a way, he was envious of their unconcern, and he often wished that more things did *not* matter so much to him. It was not that he worried—although he would readily admit to that—but rather that he was ever curious.

And he was convinced that his analysis had given him this affliction of persistent puzzling. As glad as he might be about his ability to better see himself, it was also very much as though a chronic illness had been bestowed upon him. What a burden to have—as if life were some sort of continuing mystery story whose clues were unending. However, as any lover of mysteries will tell you, following clues is a lovely addiction.

To borrow a phrase from the eminent French philosopher Ricoeur (1992), we are able to, and we should, see "oneself as another." This perception, which takes place as we step to one side of where we are usually situated, is distorted by all of the prejudices and preconceptions of subjectivity. We may, however, gain a modicum of objectivity with the aid of psychoanalysis. We do so not by sharing another's, i.e., the analyst's, subjectivity, which, although to be valued in part, is possibly merely another person's opinion. The whole point of analysis must lie in the fact that it is a body of knowledge based upon fundamental principles and ideas about transference and the unconscious.

So my patient must see him- or herself through this lens, regardless of whether he or she is more or less successful as an autobiographer. Since this autobiography is coauthored, its credibility rests upon a faithfulness to analysis, rather than to personal clarity or concealment. As a patient, one explains one's self to oneself by way of psychoanalytic understanding, while perhaps failing, more or less, as a writer of fiction, omitting something which might be more interesting and/or fascinating but less faithful to our field. The roteness of analytic lore may make for dullness of revelation, inasmuch as self-scrutiny returns again and again to situations highlighted in the treatment and faithful to our theory.

IMMUNIZATION

The return of a patient who has completed a course of analysis, now with either a concomitant return of symptoms and problems or a whole new set of difficulties, seems to happen often enough for it

to be claimed as an inevitability in the life of every analyst. With this return, there is often an implicit registering of a complaint, one that suggests a disappointment that the analysis did not quite work, did not protect the patient from further difficulties, did not bestow a sort of lifelong immunity. It is as if to say that all future troubles are essentially a return of the old ones, either in the same or in a different form, for at heart, the expected solution turned out to be nothing but a Band-Aid. This implicit complaint seeks a voice, despite the fact that time has passed, circumstances have changed, events that no one could have foreseen have occurred, and, quite likely, self-scrutiny has diminished and faded.

While we may embrace the concept of structural change as underlying analytic effectiveness, we may have to strain to account for the continued frailty of our discharged patients. We rationalize our limitations with portentous statements about the limits of analytic treatment, citing problems inherent in libidinal stickiness, or making irrelevant references to biological givens—all the while aiming to remove ourselves and the analytic method from the equation. Perhaps it is our own sales pitch, the one offered to me by one of my teachers, about the very special status of analysis that has led us into this illusion of a perfect psychic paradise. Analytic treatment, like politics, is local. It can make no claim to permanently insulate a person from the unexpected, innumerable vicissitudes of life, because, as much as one would hope, the neuroses of childhood are not complete explanations for the trials of adulthood. The above-discussed two-part explanation for the successful ending of an analysis, that of self-analysis and of open empathic connections, leads us into a clearer picture of the incompleteness of the theory of infantile neurosis and the resulting potential for analyzed patients to encounter continuing problems.

FORM VERSUS CONTENT

By advocating the making conscious of the unconscious, Freud's axiom mentioned earlier implied that psychic health was inextri-

cably tied to insight, that knowledge was empowering, and that this new power was curative. Simply put, this is a "content cure," wherein the exposure of the contents of the unconscious enables a change which, although later elaborated with various forms of energic variations, is fundamentally based upon knowing. The reexperience of the conflicts of infancy and childhood, classically thought of as infantile neurosis, should allow one as an adult to see things differently. To be sure, this reexperience requires a full affective charge to qualify as a valid one, but the original foundation was that of revisiting an earlier trauma with later *adult* competence. The transparency of the analyst, even in its guise of a neutral position (Baker 2000), insists that an earlier situation is and must be reenacted in treatment, and that this can only be effected by allowing history to repeat itself within the analysis. Such repetition involves the analyst not interfering with the emergence of unconscious material, since this material remains the root cause of the neurosis.

This is not the case with the explanation derived from "form" rather than content. Here it is not the "what" that is the problem, but the "how." For this type of patient, we shift our explanation from conflict over unfortunate discord to deficits resulting from faulty development. To be sure, one can readily see that every conflict somehow implies some sort of a deficit, either in repression, neutralization of drives, ego weakness, or any variant of alternative theoretical explanations. No matter the theory, one may still comprehend a difference between the patient who needs insight and the one who needs more, regardless of how one chooses to characterize or pathologize the latter. This second patient is the one who seems to gain relief from the regularity of visits, the listening of the analyst, the feeling of being understood—all those ingredients that are lumped together under the unhappy wastebasket term *the relationship*. This is the patient who may, upon recalling his or her analysis, speak of the analyst's tone of voice, the feelings aroused upon entering the room, the long and difficult termination punctuated by an occasional revisit, and the very expected Christmas card exchange. Often, this is also the patient about whom we may feel a

bit guilty or embarrassed: the one for whom some administrative boundary had been breached.

The thesis that I wish to offer flows from my earlier conviction that one size does not fit all, that analysis means and does different things for and to different people, and that the straitjacket-like nature of our rules leads to a rigidity in the determination of our goals. Every patient has an individual mix of self-reflection coupled with empathic connections, and one is not to be prized over the other. Indeed, this variability of needs carries over to different patients at different times, and is certainly true of one patient with different analysts. So it is only in the most general sense that we can meld together the activity of self-reflection and meaningful connections with others to fashion an endpoint applicable to any single patient. It is, however, advisable to keep in mind that we can never precisely divide an analysis into the convenient categories that we may sketch out. It is not true that we can determine exactly when we will deal with transference configurations and when with new development, or that at a particular time, we have a real relationship, and at another time, a visitor from the past. We are never so lucky.

DISCUSSION

If one were to ask a primary care physician, a college teacher, and an auto mechanic what the goals of their occupations are, they would probably all preface their responses with "it all depends." In a way, those are dreaded and dreadful words, hiding the fact that the respondents first require some input from the questioner in order to shape and determine the answer. Not so with the plumber called in to unplug your sink, the teacher of first-year French, and the internist treating a specific patient with pneumonia. The easy answers involve focused efforts at fixing a specific problem; the hard ones relate to general aims of amelioration.

Psychoanalysis does not enjoy focused fixes. As much as we would like it to be otherwise, we are haunted by vagueness. Yet this atmosphere of uncertainty makes analysis the rich field that it is,

inasmuch as, if every patient has an oedipal problem, then we are too much the plumber. "Never knowing for sure" is the proper place for our own "it all depends" and our own insistence on the individual patient finding his or her own goals.

CONCLUSION

The supposed grammatical error of my title comes from a linguistic choice. It is meant to state itself in the accusative case, i.e., as the object of a verb. It is intended to convey what the goals of psychoanalysis mean to me and to Max, since Max and I continue to think quite differently, just as I continue to live with uncertainty. The vibrancy of analysis derives from both its fundamental thesis of transference and the unconscious, and from the indeterminate shape of each of these fundamentals. To combine the two—i.e., fundamentals plus change—results in our being able to specify the goals of psychoanalysis with the addendum of some phrase like "as of now" or "for the time being," alongside "for this particular person." In this way, we can and should embrace the vagueness of our work. Max was a great teacher because he was so sure of himself—and, paradoxically, could produce a student who could live happily with a multitude of opinions.

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Psychoanalytic Quarterly, LXX, 2001

THINKING, TALKING, PLAYING: THE PECULIAR GOALS OF PSYCHOANALYSIS

BY JAY GREENBERG, PH.D.

A COMMON GROUND

Not long ago, I participated in a meeting attended by psychoanalysts representing a number of different theoretical orientations. The purpose of the meeting was to try to find ways to facilitate interinstitutional collaboration, to break down the political barriers that have isolated psychoanalytic traditions from one another for very many years. We were able to meet because of the climate of accommodation that has developed in our field over the past several years. But still there was considerable disagreement about many of the most fundamental issues in psychoanalytic theory and technique. Ranging from frequency of sessions to use of the couch, to the centrality of regression, to the need for neutrality and abstinence, the issues we debated that day have led to rancorous personal and institutional conflict, almost from the moment that Freud first codified his psychoanalytic method.

In the midst of heated discussions, I suddenly realized something that gave me a different sense of the group than I had before. I realized that all of us in the room shared something that went far beyond the details in dispute. I believe that what we shared is, more than anything else, a value system: we were all committed to the idea that if we talk to people about themselves in a way that allows them to experience and give voice to what they feel as fully as possible, we can facilitate radical changes in the quality of their lives. While we were debating, and certainly would continue to debate, the best ways

of creating these mutative conversations, we agreed (tacitly, because the area of agreement is not usually articulated) on the essential value of the project.

There is more to say about this fundamental consensus. While it united the people in the room that day, and while I believe it is shared by everyone who works as a psychoanalyst, it surely isolates us from a great many people in our society, and even from most mental health professionals. The idea that we will be helped to live better lives by getting to know, or even being curious about, the depths of our experience—by dwelling on the unbidden, the forgotten, the repudiated elements of what we think and feel—is quite peculiar. For most people, placing so much importance on the nuances of our emotional insides is the road to self-absorption at best, and perhaps even to psychic collapse. That thinking about ourselves so much can actually help is a belief that these days is held mainly by psychoanalysts.

These thoughts shape my approach to the challenge posed by the editors of this issue of *The Psychoanalytic Quarterly:* to articulate my views on the goals of analysis. For me, the issue is especially important, because I believe that psychoanalysis as a discipline is defined by its goals. This is, of course, a controversial proposition in its own right. In some views, analysis is defined by its conceptual structure—the Oedipus complex, say, or infantile sexuality. In others, it is defined by its objects of inquiry—transference and resistance. In yet others, the definition is based on specific technical measures—frequency, recumbency, neutrality. There are many points at which we may draw our lines.

But my intuition at the meeting I have described was that we all considered ourselves to be psychoanalysts because we all valued the idea of having a particular and quite unusual kind of conversation with the people who seek our help. We also shared the belief that if we could get this kind of conversation going, we could help our analysands to become interested in knowing more about aspects of their experience that they have forever rejected or disavowed. This newfound interest, in turn, would be a powerful tool for grappling with the problems that brought the patients to us in the first place. I

consider this shared vision defining, both because all analysts embrace it, and because it is so difficult to accept by anyone who is not at least sympathetic to psychoanalytic thinking.

UNIQUELY PSYCHOANALYTIC GOALS

Putting things this way leads me to a bias that I bring to the task of articulating my ideas about the goals of psychoanalysis. I believe that analysis is unique as a treatment modality, and that if it is to be viable in the intellectual or the economic marketplace, it must have unique goals. As our critics have noted for some time now, if our goals are the same as those of other treatment modalities, we are at pains to demonstrate why anybody should undertake analysis rather than some other therapy that takes less time, requires less effort, and is vastly less expensive. The traditional claim that we do it better carries little weight in the absence of anything like rigorous, comparative clinical trials. This leads me to believe that it is necessary to conceptualize a goal that can be embraced by psychoanalysts, but that does not significantly overlap with the goals of other treatment modalities.

Engaging their patients in the kind of peculiar conversations I have described is what analysts have done since Breuer first met Anna O., and Freud's earliest work was devoted to creating a framework that would make such conversations possible. What he did was, on its face, quite simple. Patients would lie down and promise to speak as freely as possible about whatever occurred to them, while the analyst, seated quietly behind the couch, would listen unobtrusively and without the burden of personal preconceptions.

But the apparent simplicity of the method is illusory, and can mask the difficulty of articulating the goals of psychoanalysis. While the idea of conversation is easily grasped (certainly in comparison with other kinds of treatment, which even in Freud's day were becoming increasingly technical), things quickly get complicated when we try to figure out just what is going on between the participants. The relationships between what is meant and what is said, between what

is said and what is heard, between what is heard and what is understood can never be fully known. As a result, conversations—even psychoanalytic ones—are always interactions, and human interactions are among the most complex and elusive phenomena to describe, much less to explain.

Because of this, it is possible to develop a wide range of theories about what is actually going on in analytic sessions. Freud himself had one theory: the conversation, with all its constraints, constituted a more or less straightforward exchange of information. Participating in the prescribed way would make it possible for the analyst to notice gaps in the patient's story—events or affects that had been renounced in the service of the patient's accommodation to the pressures of social living—and to supply the missing links that had been replaced by crippling neurotic symptoms. The patient, of course, was not expected to be able to convey the information exclusively in words. As a result, the analyst also had to pay attention to acts—the silences or diversions by which resistance became manifest, acting out, the failures of self-observation that led to urgent transference demands, and so on. But the analyst was expected and required to limit his or her participation to words, and Freud believed that the process could be adequately conceptualized in terms of the information passed back and forth.

QUESTIONING FREUD

Not surprisingly, shortly after Freud described his method, other analysts started coming up with their own theories about what was actually happening in the course of the conversation. In his second ever letter to Freud—a letter expressing deep support and appreciation—Jung voiced a crucial doubt: "Your therapy seems to me to depend not merely on the affects released by abreaction but also on certain personal rapports" (McGuire 1974, p. 4). That is, more must be going on in the Freudian conversation than revealing and feeling what had previously been repressed. The nature of the analytic conversation, and the effectiveness of treatment, Jung guessed, must

also involve something happening interpersonally between the analyst and the analysand. In the early days of analysis, this vision of the treatment process, quite different from Freud's, was articulated most clearly by Ferenczi and Rank (1924), who argued that the patient's experience with the analyst was at least as important an element of what was happening as retrieving repressed information.

Some of the most interesting and important shifts in psychoanalytic understanding grew out of reinterpretations of the events that transpire in analytic sessions and of the meanings that each participant attaches to them. Two of the most prominent and influential examples explicitly address what had previously been inattended aspects of analytic interaction. Strachey (1934) theorized that patients internalize the analyst's neutral stance in a way that softens the harshness of an archaic superego. This pointed toward a new understanding of the effect of the analyst's presence, an effect that had not previously been conceptualized and that may even elude the conscious awareness of both members of the analytic dyad. Similarly, Loewald (1960) suggested that the analyst's participation revitalizes a stalled process of ego development. This is possible, Loewald believed, because the analyst meets the patient in a way that, optimally, very young children are met by their mothers. Like Strachey, Loewald included the nonverbal effects of the analyst's presence among the forces that contribute to the therapeutic action of analysis.

Significantly, neither Strachey nor Loewald argued for any changes in standard analytic technique. Rather, each suggested that analysts, simply by behaving in the way that they always had, were doing something that they had not realized they were doing. Freud's "simple" method was turning out to be not so simple at all. Just what we are doing when we do psychoanalysis proved to be both extremely interesting and extremely difficult to grasp.

In today's psychoanalytic world, the problem of what we are doing with our patients is, of course, increasingly vexing. While Strachey and Loewald raised the crucial questions without challenging the received method, today's analysts of almost all theoretical persuasions feel freer to engage their patients in ways that were once ruled out of the technical canon. There are many more things that we, as

analysts, can do: making expressive use of the countertransference, as well as accepting or even embracing the value of various kinds of enactments, are the tip of the iceberg of what I have in mind. The potential meanings of this newly expanded repertoire, and the consequent possibilities for conceptualizing what is consequential about the events of an analysis, have ramified enormously. Few, if any, contemporary analysts would claim, with anything like Freud's certainty, that they know very much about what happens over the course of treatment.

The difficulty of knowing what we *are* doing when we do analysis makes it difficult to formulate what we *want* to do. Following Jung's intuition and Strachey's and Loewald's more developed formulations, we know that when we invite our patients to join in an analytic conversation, we also offer them an intensely personal and historically evocative relationship. We also know that the conversation, the new information that emerges from it, and the nonverbal aspects of the relationship are experienced by the analysand in many ways, some of which we may grasp, others forever eluding understanding. In turn, these experiences are internalized so as to reorganize and restructure the psychic landscape. Of the many things we do with our analysands, of the many ways in which we touch their minds and their lives, is it possible to choose one as a primary or superordinate goal? Is the risk of reductionism so great the we are better off rejecting the challenge from the outset?

FREUD'S FORMULATIONS OF PSYCHOANALYTIC GOALS

Our problem is not new. Freud himself had trouble with the question of analytic goals: he came up with a number of quite different formulations of what he was trying to accomplish. In fact, it is probably fair to say that Freud was less clear (and more open to change) about his clinical goals than he was about what was happening in the consulting room. Consider his three most famous formulations of the aims of psychoanalytic treatment:

1. In the final paragraph of *Studies on Hysteria,* he summed up the kind of "help or improvement" that he intended to offer his patients: ". . . much will be gained if we succeed in transforming your hysterical misery into common unhappiness" (Breuer and Freud 1895, p. 305).

2. Shortly after he had arrived at a final version of his technique, Freud offered three ways of describing "the task which the psycho-analytic method seeks to perform": we must aim, he wrote, "to remove the amnesias . . . [or to put it another way] . . . all repressions must be undone . . . [or] the task consists in making the unconscious accessible to consciousness" (1903, pp. 252-253; this formulation was repeated in almost the same words in 1916-1917, p. 435).

3. In summing up late in his career, after formulating the structural model, Freud described the "intention" of psychoanalysis as the strengthening of the ego, giving rise to the evocative promise that "where id was, there shall ego be" (1933, p. 80).

By examining the relationships among these propositions, I hope to arrive at some ideas about the nature of psychoanalytic conversations, and to tease out a way of talking about our clinical goals that is unique to psychoanalysis, distinguishing it from other forms of treatment. Two ways of conceptualizing these relationships occur to me.

First, following a tendency familiar in Freud's commentary to impose a unity on his thinking, we might say that these propositions represent three facets of the analytic process. Each formulation emerged under the sway of the theory Freud was using at the time, so the emphases and the language in which they are expressed differ. If we want to find unity, we might say that making the unconscious accessible to the conscious is an intermediate goal. To put it another way, it is a formulation of the nature of the analytic work itself. When successful, this work influences the structure of the analysand's mind, bringing about changes that can be conceptual-

ized (at varying levels of abstraction) as bringing the irrational under the aegis of the rational, converting free into bound energy, expanding the domain of the ego into regions previously ruled exclusively by id. The effect of these structural changes—the goal toward which the treatment ultimately aims and without which all the work would hardly be worth the effort—is to cure neurotic misery. Freud's tragic vision of human experience (Schafer 1970), however, required him to remind us that ordinary unhappiness is always a fact of life, and that it cannot be cured.

This way of looking at things reconciles apparently disparate formulations, leaving us with an articulated treatment goal. But that statement of the goal, curing neurotic misery, is unsatisfactory both on account of its vagueness and because it is not uniquely psychoanalytic. It would, in fact, characterize virtually any therapy, and analysis would appear to aim at a conventional result achieved through unconventional means. Behavioral and cognitive therapies might certainly make the same claim. I could even imagine drug companies proclaiming that their products will "[transform] your hysterical misery into common unhappiness," although this would arguably be a poor advertising slogan. Psychoanalysis, I believe, aims at something different, something that offers less a cure than the possibility of radically transforming our way of life.

I want to suggest a second way of thinking about Freud's various statements. Rather than trying to reconcile them, we might say that each reflects a unique perspective on the analytic enterprise, informed by Freud's clinical experience at the time he offered it. Each offers a sense of what Freud was trying to do when he was doing analysis, and how he was thinking about what he was trying to do. Freud's thoughts changed over time, and the goals as he conceptualized them are not necessarily in accord with one another. Perhaps they reflect his always-shifting intuition about what constitutes the most salient elements of the analytic conversation.

With this view in mind, and perhaps curiously, the goals most compatible with each other are those Freud formulated at the beginning and then at the end of his career as an analyst. In his early days of working analytically, Freud's concern was exclusively on ridding

his patients of their hysterical and obsessive-compulsive symptoms. In *Studies on Hysteria,* accordingly, he was at his most eclectic and most pragmatic; although his goal was simply stated, his methods were wide-ranging. In addition to employing conventional treatments (massage, hydrotherapy, rest cures), he used hypnosis in a variety of ways. Not only did he encourage his patients to retrieve lost memories and to abreact stifled emotional experiences, but he was willing to suggest away symptoms and even to try to erase painful memories (for example, in the case of Frau Emmy von N. [Breuer and Freud 1895]). He would do whatever was necessary to facilitate the goal of relieving neurotic misery.

Because treatment revealed that a great deal of neurotic misery was caused by the repression of important experiences (trauma and/or intolerable conflict), undoing repressions became the keystone of Freud's method. At this time, however, it was not a goal in its own right, but rather a means to an end. Freud's early pragmatism dictated that therapy could include any technique that would help the patient to get rid of his or her crippling symptoms.

But as he learned more from doing analysis, Freud realized that he had created a powerful tool for the investigation of the human mind. Always inclined to value discovery over therapy, he reformulated his statement of analytic goals. It is striking that symptom removal is not mentioned in the 1903 or 1916-1917 definitions of the psychoanalytic task, and making the unconscious accessible to consciousness seems to have become a value in its own right. Certainly, Freud continued to see analysis as a therapy, but he was also becoming increasingly pessimistic about the possibility of achieving the complete "cure" that he had once hoped for. Curiosity and self-awareness were becoming not only the means, but the end as well.

But things changed again as Freud came increasingly to appreciate the importance of character in shaping his analysands' difficulties. His later patients—many of whom sought analysis for training purposes—did not present with any manifest symptoms (hysterical paralyses, obsessive thoughts, and so on). But despite this, they were certainly plagued with more than their share of ordinary unhappiness. In fact, the early, clear-cut distinction be-

tween neurotic misery and ordinary unhappiness was becoming considerably blurred. In light of this, Freud came to believe that changes in character could touch the tendency (expressed in technical terms under the rubric of the repetition compulsion) to submit to and even embrace unhappiness.

But how to go about facilitating characterological change? In many cases, Freud noted, making the unconscious conscious turned out actually to increase the analysands' share of quotidian misery. Accurate interpretations, far from opening up the possibility of more freely adaptive functioning, made some patients worse. This "negative therapeutic reaction" must have raised questions in Freud's mind about whether making the unconscious conscious—whatever its intellectual appeal—was an adequate fit with what was still, at least to some extent, a therapeutic enterprise. It was in this context that Freud reformulated his analytic aims, returning implicitly to the eclecticism of his earlier days. Now, instead of making the unconscious conscious, he invoked the expansion of ego as a goal.

Let us consider the effect of this new way of conceptualizing his goals. The ego of the structural model is, above all, a product of developmental experience. A "precipitate of abandoned object cathexes" (Freud 1923, p. 29), ego grows from living in the world, the world of reality in general and of other people in particular. Ego is a product of our immersion in the interpersonal world; its growth is shaped and facilitated by everything that is involved in living in the world. As Freud put it when he characterized the psychoanalytic process, "It is a work of culture" (1933, p. 80).

This "work of culture" was originally mediated by the impact of people in the growing child's environment, and is now carried forward by the analyst. But how is the analyst to accomplish this? It is hard to see how simply interpreting unconscious mental contents could be up to the job of acculturation. Freud himself was never very explicit about what the analyst might do that would promote ego growth, although he did suggest that he had a broader view of the analyst's role in mind. In *An Outline of Psycho-Analysis,* in a passage that included mention of the analyst's efforts to make the unconscious conscious, Freud added: "We serve the patient in various

functions, as an authority and a substitute for his parents, as a teacher and educator . . ." (1940, p. 181).

This new formulation of what an analyst does and might want to do departed considerably from Freud's previous statement of analytic goals, although characteristically, he did not make the departure explicit. Perhaps because he was reluctant to spell out exactly what he was doing with his patients, however, Freud still appeared to be saying that the ego grows and gains strength as a direct result of being able to allow previously repressed psychic contents into consciousness. If so, "where id was, there shall ego be" represented simply a restatement of the earlier expressed analytic goals, now stated in the language of his structural theory. But today, we have more information and new ways of thinking about ego development, and these raise new questions about the relationship between self-knowledge and structural change.

Recall that Freud's earliest psychoanalytic insight was not only that we keep ourselves unaware of a great deal (vulnerability, sexuality, need, capacity to damage those we love, disappointments, and so on), but also that we do so for very good reasons. Both our minds and our relationships are designed, in some measure, to ward off painful self-awareness. In many respects, we all intuitively behave in ways designed to make what is conscious unconscious. Freud saw this behavior—intrapsychic, and at least by implication, interpersonal—as the ultimate source of neurotic psychopathology.

PSYCHOANALYTIC GOALS TODAY

A century of clinical experience has revealed what Freud could not have known early on, that while pushing away what is most troubling in our experience *may* be pathogenic, it can often create a space in which quiet growth becomes possible. "It's just a dream," every parent has told their frightened child in the middle of the night, and that is, of course, the right thing to say. The parent's soothing presence calms the child and makes it possible for natural processes (relaxation, sleep) to do their work and get the child past a moment of

disruption. It is not a very big step from this scenario to envision a calm and authoritative Freud telling his hypnotized patient in the early days that it is all right to forego her symptom, or to erase the traumatic memory that she has suddenly recalled.

Both the parent and the hypnotist are acting in ways likely to contribute to ego development, by protecting it from outside impingements. Doing so means working to keep certain mental contents unconscious. Approached from this vantage point, the relationship between Freud's two most widely quoted statements about the goals of psychoanalysis—making the unconscious accessible to consciousness and expanding ego into the domain of id—appears increasingly complex. We can see how the two might work together, facilitating each other, but we also know that they have the potential to be at odds with each other. Thus, at some times, promoting curiosity and self-awareness makes for a more resilient and therefore stronger ego. In turn, a strengthened ego plays more effectively, tolerating more self-exploration and more consciousness of what had been warded off. But at other times, self-awareness can be too much of a shock, and the analysand's reaction will be to constrict the ego, to forego psychic freedom in the service of self-protection.

These considerations bear directly on the problem of the goals of psychoanalysis because they address the many ways in which the analytic process can facilitate therapeutic change. Building on the work of Strachey and Loewald, the writings of many contemporary self psychologists and relational psychoanalysts are devoted to spelling out change that grows out of the experience of being in treatment, experience that need not be verbalized and that may never even reach consciousness in any articulated way.

An intriguing source of converging thinking comes from work being done in the neurosciences. Recently, a developing consensus has been that there are any number of unconscious registers of experience. Some of these—notably, implicit and procedural memory—can be influenced by nonverbal experience. This proposition supports the idea that a relationship as intense as the one between analyst and analysand is likely to influence not just the mind, but

also the brain itself, in ways that elude translation into words (Westen and Gabbard, in press; Gabbard and Westen, in press). The kinds of transactions likely to mediate this influence, like the kinds of transactions that mediate normal development, are the events implicit in Freud's "where id was, there shall ego be."

But our new awareness of all that is going on in every analysis highlights our original question: Where in all this can we locate a unique analytic goal? The new thinking in both analysis and the neurosciences leaves us with a major paradox: We know that it is possible to influence the unconscious without thinking about it or even believing that it exists. Without doubt, much of what we have historically seen as the therapeutic benefits of analysis grows out of the ways in which the analytic relationship influences nonverbal regions of the mind/brain. The same can be said of the therapeutic effects of other treatment methods.

In light of this, does it make sense to separate out any one effect from all the other results achieved in every analysis, and to label that effect a goal? I believe that it does make sense, that we should at least make an effort to articulate a unique goal. What makes doing so a worthwhile project is that it has significant implications for the way we work clinically.

Consider a simple and commonplace clinical example. A patient who has grown up scathed and tied to an angry, brittle, and needy mother is prone to hear virtually any interpretation of her own anger as an intense criticism. If she thinks that the analyst disapproves of her—and she does whenever her anger is treated as anything but justifiably reactive to the behavior of somebody else—she withdraws into a state of self-protective isolation until she feels safe enough to change the subject and reenter the analytic conversation.

This is somebody with whom, I suspect, virtually any analyst would walk on eggshells, sensing that it will take some time before she will be ready to look very hard into her own aggression. For example, she is prone to missing sessions—not very often, but frequently enough that it is noticeable. She feels guilty and ashamed when this happens, but is quick to explain it away with a logistical excuse. Any attempt to raise questions about her motivation for missing

leads to intense anxiety and withdrawal, and addressing the guilt or shame has much the same effect.

Treading very lightly, or perhaps not at all, on the missed sessions is the kind of nonverbal intervention that will facilitate the growth of this analysand's ego. By demonstrating a resilience and at least a tacit willingness to forgive, the analyst can provide a relational experience that is quite different from her experience with her hypersensitive, quick-to-blame mother. The analyst contains the patient's aggression and provides a space within which it can be expressed without dire consequences. In turn, the patient becomes more comfortable in experiencing it, and is able to talk about it more directly. When this happens, the peremptory acting out that is the id's way of working has been replaced by thinking, delay, and words—the way of the ego. The goal of promoting ego development will have been reached at this point.

What I have described so far is likely to happen in every analysis, and in many other kinds of therapy as well. The difference between the goals of various treatment modalities depends on the conceptualization of what has happened. For the analyst, whose goal is to make the unconscious conscious, the patient's new ability to identify and talk about her anger will be but one step on a longer path. The analyst will not be satisfied with making it possible for the analysand to feel anger, or to be able to express it, or even to feel comfortable with it. Rather, the goal is to help the analysand to become interested in, and to the extent possible, to know her anger—including all the discomforts that come with being angry and all the compromises that she makes in the service of assuaging her anxieties about being angry.

This difference in goals will shape the analyst's stance and attitude in doing the work; he or she will engage the analysand in a subtly but palpably different way. For example, the analyst will not believe that any goal has been reached when the analysand has recognized or expressed her anger. In fact, the analyst will be as open to what is *not* being recognized and talked about when the analysand is verbalizing her angry feelings as he or she was when the analysand was acting them out.

In holding to this attitude—in embracing the goal of making the unconscious conscious—the analyst asserts his or her belief in the value of conversation, in the analyst's presence when it is possible and necessary, and internally when it is not. In a recent paper, Hopkins (in press) summarized Phillips's (1998) comment that "the major goal of effective analytic intervention is to help the patient re-access his/her infantile curiosity about the world. The capacity to be curious is far more important than the possession of insight." It is debatable whether Freud would have or could have distinguished curiosity from insight. But what is certain is that he created a process that, at its best, opens us to our experiential worlds in ways that vitalize a capacity to be curious, a capacity that has not only been lost, but that may be terrifying as well.

The difference in goals not only shapes the analyst's behavior, but also affects the analyst's understanding of the meanings of what he or she does. In my clinical example, the analyst experiences treading lightly on the analysand's masked aggression very differently than would a therapist who aims at promoting the growth of the ego. Because the analyst's goal is to help the patient think about all the ramifications of her anger, it is difficult for the analyst to see him- or herself simply as offering the patient a safe environment within which she can express herself freely. Rather, the analyst is aware that he or she may also be luring the patient into a terrifying netherworld from which she can imagine no escape. Mindful that whatever the patient does in response to interventions expresses both her hopes and her fears, her new openness to experiencing her anger and her terror of it, the analyst sees her actions not as an end in themselves, but as an ambiguous element of a continuing conversation. The analyst always holds open the possibility that any direct expression of anger betrays the patient's fear of further exploration, rather than signaling that she is feeling safe enough to act differently than she has before.

And this leads to a further, vital implication of the goal of making the unconscious conscious. In urging us to follow that path, Freud was also asking us to recognize that there are aspects of our anger that we can never know. A paradoxical effect of the insistence on un-

derstanding ourselves is to recognize the limits of understanding itself. Accordingly, the analyst who embraces that goal will be playful with whatever the analysand does, but he or she will be less optimistic and more uncertain about having arrived at any particular developmental endpoint than most therapists can or want to be (Kuriloff 2000).

CONCLUSION

Let us take a fuller look at Freud's (1916-1917) formulation of psychoanalytic goals in his *Introductory Lectures*. After indicating his intention to make conscious what is unconscious, he quickly addressed what he assumed would be the reader's disappointment:

> But perhaps you will be dissatisfied by this admission. You had formed a different picture of the return to health of a neurotic patient—that, after submitting to the tedious labors of a psycho-analysis, he would become another man; but the total result, so it seems, is that he has rather less that is unconscious and rather more that is conscious in him than he had before. [p. 435]

In putting it this way, Freud acknowledged that his goal was more modest than it had been (ridding the patient of neurotic misery), and that the inner changes the analysand achieves are more specific than they will be later on (replacing a bestial id with a civilized ego). But there is more to the story than that, as explained in his further comment that "the neurotic who is cured has really become another man, though, at bottom, of course, he has remained the same; that is to say, he has become what he might have become at best under the most favorable conditions" (p. 435).

Freud thus expressed a commitment that was not only clinical, but profoundly ethical and aesthetic. What a person "might have become at best" is someone who is capable of self-examination, of thinking about but not necessarily mastering—or even fully know-

ing—his or her own experience. "Better to be Socrates dissatisfied than a fool satisfied," wrote John Stuart Mill (1863, p. 20), and "Know yourself" was the great ethical imperative that guided Socrates' life. In our society, fascinated as we are by technology and cynical about what human passions have wrought, psychoanalysts are among the few who still believe that we become our best through self-reflection. I can think of no better reason to embrace the arduous, always unfinished struggle to know ourselves as our psychoanalytic goal.

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Psychoanalytic Quarterly, LXX, 2001

REFLECTIONS ON THE GOALS OF PSYCHOANALYSIS, THE PSYCHOANALYTIC PROCESS, AND THE PROCESS OF CHANGE

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As I began to reflect on the goals of clinical psychoanalysis and how I have thought about this topic over the years, a memory came to mind. It related to an incident that took place some years ago at the dawn of the Women's Movement, when most male analysts wore their chauvinism like a comfortable old cardigan.

At that time, a young and determinedly militant feminist came to see me. (Why, given her none-too-friendly attitude toward men, she chose to consult an older man—and according to my wife and daughters, an inadequately liberated one at that—was a puzzle that became the subject of much analytic investigation.) In the initial interview, Ms. N, a large, heavyset woman, sat on the edge of her chair, her back straight and taut and her feet planted squarely in front of her. Leaning forward and fixing me with a distinctly menacing stare, she launched an interrogation worthy of the best-trained counterintelligence operative.

What were my political beliefs, she wanted to know. Whom had I voted for in the last election? What feminist authors had I read recently? Was I a hard-core (i.e., politically incorrect) Freudian, or did I embrace Modernist thinkers like Horney, Foucault, and Friedan?

In my most tactful analytic style, I tried to parry these questions, but Ms. N brushed aside such efforts at evasion. She demanded to know what I actually believed in. What were my ideas about the inequities in our society and what was I doing about them, she asked in a tone that, moment-by-moment, grew increasingly insistent.

"I'm into consciousness raising," she finally announced defiantly. "What are you into?"

Completely nonplussed, not knowing how to respond, I sat staring dumbly at the patient for what seemed like minutes. Then, out of nowhere, a response leapt to mind. "*Un*consciousness raising," I replied.

Later, looking back on that incident, I realized that what had popped out of my mouth at that moment, was, in fact, the truth. The raising and recovery of the unconscious was what, as an analyst, I then sought to achieve. Clearly, I and most of my colleagues trained in the classical tradition subscribed without question to the view that the central goal of analysis is the uncovering of unconscious fantasy: the reintegration, in other words, of those aspects of the patient's inner world of imagination and fantasy that are unacceptable to him or her, and that as a consequence have been displaced, projected, driven underground, or otherwise warded off. Our task, to be accomplished through interpretation, was the reclamation of the lost and alienated parts of the self. Once identified and made conscious, they could be reappraised by the patient's adult ego, tested against current reality, and, where appropriate, modified and let back into the system.

TRADITIONAL PSYCHOANALYTIC GOALS

Most of us, I believe, were strongly influenced by Freud's (1933) dictum, "where id was, there ego shall be" (p. 80). Early on, however, we learned that as far as having the capacity to wreak havoc with a life the superego is the equal of the id, so that when we encountered a patient in analysis who suffered under the lash of such a punitive conscience, we sought, through interpretation, to extend the ego's control over the superego as well.

It was that time in America when ego psychology was in the ascendancy. Its star shone bright, particularly in the New York heavens, and Hartmann, Kris, and Loewenstein, all teachers at the New

York Psychoanalytic Institute, were its explorers and champions. In that atmosphere, and under their tutelage, we students put much faith in the ego's ability to synthesize and harmonize unruly elements in the psyche, once these dark forces were exposed to the light of day. By means first of defense analysis and then of interpretation of the underlying fantasies and belief systems, these sources of pathology—clearly the cause of our patients' troubles—could be rooted out, or so weakened by their recovery and reexamination that in essence they lost the power to cause harm.

Inherent in this view was the long-held belief that insight—and pretty much insight alone—was the curative factor in analysis. Once the pathological fantasies were exposed, in other words, and insight into their sources, origins, and current defensive uses was achieved, the ego's ability to utilize this knowledge—that is, to dispel the old anachronistic beliefs and integrate new knowledge that came with insight—was taken as a given.

As for the concept of working through (i.e., the gradual forging of change by means of the repeated interpretation of defense, conflict, and unconscious fantasy), we shared Brenner's (1985) view that this concept is, in essence, a redundancy. All of analysis, Brenner taught, involves the very processes said to be characteristic of working through. In short, for him, working through is nothing but the slow, painstaking analytic process itself, a process that, if skillfully carried out, and if the patient's psychopathology is properly understood and interpreted, results in the substitution of healthier, more adaptive compromise formations for the pathological ones that lay at the root of the patient's suffering. At that time, we viewed the analyst's psychology, unless it took the form of clearly troublesome countertransference responses (countertransference was then regarded solely as a potential interference in analytic work), as a negligible factor in analysis. The well-analyzed analyst, we were taught, was a more or less objective observer, one whose ability to understand the patient correctly was not significantly influenced by subjective factors. This is a view still held today by a number of highly respected analysts.

THE INTERPERSONAL SPHERE

The idea that unconscious communications flow continuously between patient and analyst, and that these covert communications exert an ongoing, often critically important influence on the course of the analysis, was not part of earlier analytic understanding. Nor was there appreciation of that aspect of analysis that constitutes a multifaceted experience, including a unique human relationship whose effect on learning, the unconscious, and the structure of the mind is unquestionably profound, an aspect of the analytic encounter that is only partially encompassed by our concept of transference. Such a view was—and to some extent remains—anathema to classical analysts, who viewed any interest in the interpersonal sphere as essentially nonanalytic, antithetical to the depth psychological approach that constitutes the essence of true analysis. As a result, the effect on the analytic process of covert messages, including nonverbal communications, that were regularly transmitted in the analytic hour was a phenomenon largely overlooked in traditional analysis.

Although formed as a result of many forces operating at the time, including political and historical ones, the position of traditional analysts has also reflected the long-standing fear that the interpersonalists' influence would result in the loss of the core of analysis, its very essence. This position, in fact, has had an enduring impact on mainstream American analysis. Its legacy has been that until quite recently, the intersubjective dimension of analysis was largely ignored in classical analytic institutes, and was not explored as an integral part of the analytic process—that is, as a phenomenon not divorced from the inner world of imagination and fantasy, but as an ongoing contributor to, and active influence on, the shape and form of that world.

PSYCHOANALYSIS AS AN EFFECTIVE TREATMENT

With regard to analysis as a method of treatment and the role of the analyst in the treatment process, the approach I learned was

a rather arms-length one, very much in keeping with the view of analysis as a reasonably objective enterprise and of the analyst as an objective enough observer. The aim of analysis was clear: it was to acquaint the patient with the workings of his or her own mind. That was the purpose—to increase the patient's understanding of powerful forces operating outside of awareness that influenced his or her thinking and behavior.

What the patient did with this knowledge was another matter. While the analyst kept one eye on the patient's life, interpreting conflict and fantasy as it was played out in that arena, the analyst's primary interest was in the inner world of imagination and fantasy and the way that inner world was lived out in the transference. We believed that understanding and working through of conflicts in the transference was a route—really the *only* route—to analytic change. If the transference was sufficiently engaged and the patient's long-standing conflicts interpreted in the immediacy of the transference moment, we had little doubt that shifts in the balance of forces in the mind would take place. And sooner or later, we were convinced, these internal changes would result in significant changes in the patient's life. Even if there was little evidence of such movement at termination, we had faith that in time it would take place.

Sometimes it worked out that way, but often it did not. All too frequently, it happened that, despite learning much about themselves in analysis, patients were able to change little, either during or after treatment. Nor were they content with this result. It soon became clear that, although we analysts might have believed that learning how one's mind worked was a worthy and sufficient analytic goal, few of our patients agreed with us. In fact, many patients, including a good many analytic candidates, came away from their treatments with a keen sense of disappointment. And as the number of such patients grew, the reputation of analysis declined.

Of course, a number of other factors contributed to this situation, including economic issues, changes in societal values, and the postwar idealization of analysis as the long-awaited cure for man's ills, an attitude that set the stage for the disappointment and dis-

illusionment that inevitably followed. It was also true, however, that as a treatment, analysis had not lived up to its early promise.

It soon became apparent that a significant gulf existed between psychoanalysis as an explanatory system, a science of mind as it were, and analysis as a treatment. Over the years, the basic assumptions of the former have won quite general acceptance, even among those colleagues who take issue with one or another aspect of theory. With the latter, however, there has been, and continues to be, not a little discontent.

Personally, I believe that one of the chief motives underlying the current call for revision in analytic technique stems from disappointment in their own analytic experience on the part of many who are most vociferous in calling for change. Whether or not this has been generally true of innovators in our field—I suspect that it is one factor in their psychology—the history of innovation, if not progress, in analysis, from Ferenczi to Kohut, from Rank to Renik, could be written from the standpoint of the search for more effective treatment—the ongoing quest to devise a method, a way of working, that does a better job than we do now, not only of helping patients get in touch with their inner worlds, but of forging change.

I, too, have been keenly interested in the question of the effectiveness of analysis; I refer to analysis here not only as an experience that expands understanding, but as a treatment method that helps our patients overcome the pain, anxiety, and troubled relationships that have caused so much difficulty in their lives. Increasingly, I have come to share my patients' view that, as important as it is—and unquestionably, it is of the greatest importance in paving the way for change—understanding the workings of one's mind is not a sufficient analytic goal. Too often in my work, I have witnessed the development of insight that remained just that: insight in a vacuum, insight divorced from action or change, understanding that had little impact on the patient's life or the difficulties that brought him or her to treatment.

In these cases, despite repeated, and I believe quite accurate, interpretations of key conflicts and fantasies both inside and outside the transference, the patients were unable to loosen the bonds that

kept them fettered, bonds that held in place the old, familiar patterns, the old ways of living and experiencing the world. Accordingly, I have found it important to include in my conception of the goals of analysis the idea of effectiveness—the attainment, that is, not only of insight and extended self-understanding, but the capacity to utilize that understanding in the service of effective, personally meaningful change.

THE PROBLEM OF INTRANSIGENCE

Every analyst must contend with the kind of patient I have mentioned: an individual who, although not suffering from deep-seated pathology and seemingly analyzable, is nevertheless unable to make effective use of the analytic process. It was patients of this kind, I believe, that Freud had in mind when he reflected on the problem of intransigence in *Analysis Terminable and Interminable* (1937). This essay, quite pessimistic and even fatalistic in tone, has had a strong impact on analysts working with such highly resistant patients. These patients regularly evoke feelings of frustration, helplessness, and discouragement in the analyst, and under such circumstances, it is both appealing and comforting to explain their lack of progress on biological grounds, or as the result of fixations so deeply ingrained that analysis is powerless to affect them.

For some patients, of course, this explanation is correct, and in these cases, it is indeed such underlying problems that severely limit what analysis can accomplish. But that is not always the situation. In not a few analyses, other factors—including subtle transference-countertransference interactions, the influence of previously undiscovered aspects of the patient's history, and the communication of covert resistances in the analyst to change in the patient (Little 1951)—contribute in important ways to the lack of movement. The strain of working with such intransigent (and frustrating) patients is such, however, that there is a readiness on the part of many analysts to invoke Freud's notion of unchangeable, bedrock resistances to explain the failure to progress.

Many times in my own experience with such unchanging and seemingly unchangeable patients, I have seized upon this comforting explanation—essentially, it absolves the analyst of blame for the impasse—but I have learned that when my thoughts turn to biological causes or immovable fixations, this is a sure sign that just beneath the surface, warded off by such ideas, I am struggling against feelings of discouragement and despair. And when this happens, I have also learned to turn back to the clinical encounter, and to reexamine what in recent weeks has been happening between the patient and me. In particular, I attempt to take a close look at my countertransference and at what, covertly, I may have communicated to the patient. I also find it useful to review the patient's history, in an effort to make certain that I have not overlooked some aspect of his or her prior experience being reenacted through a lack of movement in the analysis. In some cases, I have discovered that this problem is in part related to a long-standing but unconscious fear of physical movement, a problem dating back to early childhood and reflecting anxieties over locomotion which developed at that time. (I will have more to say about this issue presently.)

The approach I have described reflects the influence of several factors: my belief that the goals of analysis should include positive life changes; an equally strong belief that our understanding of what happens or fails to happen in our patients in that dark area between insight and change is inadequate and requires further study; and greater clinical experience, which has taught me to examine more closely than I used to do all the factors, including well-concealed ones, that might be contributing to the patient's inability to make effective use of the insights achieved.

CLINICAL VIGNETTES

I will describe several cases which had in common the seeming inability to change. In each of them, this problem reflected not bedrock resistances or deeply ingrained fixations, but factors in the psychology of the patient and/or of the analyst, and in the interaction between them, that operated to block progress. Uncovering and

working through these underlying issues made it possible for the patient to move toward the goal shared by patient and analyst of achieving not only insight, but positive life changes as well. Perhaps what I will have to say about these cases—what I discovered in working with them—will be quite familiar to the reader. In that event, I hope that the clinical vignettes themselves, along with some thoughts I offer about the analytic process, will prove to be of interest.

Mr. C

Mr. C's fondest wish was to stay in analysis indefinitely. Taking issue with the idea of termination, he contended that outside of blind convention, there was no reason whatsoever to put an end to an experience that he found satisfying and useful. "If it's not broken, don't fix it," he said, with clear awareness of the irony involved.

The issue of change or progress in analysis, however, was another matter, one that seemed not to interest him at all. From early on in the analysis, in fact, it became apparent that Mr. C was more interested in the relationship with me—literally in being in my presence—than he was in using insight to effect inner change. It was not that Mr. C was incapable of attaining insight; to the contrary, a psychologically minded individual, he was quite intuitive in grasping unconscious motivations. This understanding, however, Mr. C regularly applied more to others than to himself. He developed considerable skill in analyzing the conflicts and motives of friends, family, and business associates, and he regarded his ability to do so as both the product of his analysis and one of its chief benefits.

Also gratifying and reassuring to Mr. C was his conviction that I would not let him make a grievous error. As long as he was in treatment, he believed, I would be available to monitor his decisions and to forestall the kind of impulsive, ill-considered actions that as a young man had caused him much trouble. For him, in short, I was the wise and knowledgeable father whom he never

had. Suffering a fatal heart attack when the boy was only eight, Mr. C's father was unable to be the kind of guide and model that Mr. C yearned for and sought in our relationship.

As one can imagine, over the years, Mr. C and I analyzed every conceivable facet of his psychology. In the transference, we explored not only his need for me and his fantasies of not being able to live without me, but identified some of his rivalrous and resentful feelings toward me as well. In that connection, we uncovered the fantasy that if he were to make sufficient progress in treatment so that he could actually terminate, this would be the equivalent of attacking and destroying me. So frightening was this idea, a fantasy rooted in childhood death wishes toward his father that had become all too real when he actually died, that Mr. C never allowed himself even to think about ending.

In time, we came to understand, too, the way in which Mr. C unconsciously experienced me as the mother of his early years—the mother who represented an island of safety for Mr. C, and who, after his father's death, he clung to as his only parent. And because he was terrified of losing her, Mr. C kept his negative feelings toward his mother well under wraps. This was a pattern that, unconsciously, he played out in the transference. While it produced much understanding, all of this seemingly important analytic work had little effect on Mr. C's way of living and being in the world. Psychologically and in his behavior, he was at the old stand, doing business as usual.

What ultimately made a difference in Mr. C's treatment—what made it possible, finally, for him to achieve genuine progress and to terminate—was not further analysis of his issues, but the long-delayed understanding of and grappling with my own issues. In time and with the help of consultation, I came to realize that what was being enacted in this treatment was a set of dual wishes—not only Mr. C's wish for me to be the father who had been taken from him, but also *my* wish for *him* to be the fantasied father whom I never had. Prosperous, successful, and active in the world, in many respects, Mr. C was the kind of man whom, in childhood, I had wanted my father to be.

In our relationship, then, each of us unconsciously fulfilled a long-standing dream of having a father who not only would provide many of the gratifications that we had missed, but who would have the power to endow us with his own strength, talent, and wisdom. Furthermore, I realized, shamefully, that I had become dependent on the considerably substantial fee that Mr. C paid me. And it was not only the money itself that I valued. The idea that this man whom I respected and admired was willing—in fact was glad—to offer me a substantial sum, while my own father, financially strapped, could give me comparatively little, clearly touched far more than it should have on issues having to do with my self-esteem.

Due in large measure to the playing out of these unconscious needs in patient and analyst, then, Mr. C had been unable to grapple adequately with his underlying feelings of competition and aggression toward me—and ultimately toward his father—that he needed to engage and work through if he were to move ahead and make progress in treatment and in life. And his inability to do so stemmed not only from his fear of disrupting a relationship that he very much needed. For my own reasons, I, too, was unwilling to disturb the status quo. Thus, unconsciously, I joined in a collusion with Mr. C to avoid dealing with the resistances that kept him from fully experiencing his negative feelings toward me.

It was not that we did not speak of these issues. As noted, I sought to identify and interpret them as they arose in the transference. But there is interpretation and interpretation. While we talked about the issues, our mutual need to maintain the relationship we needed led us to do so in a way that subtly conveyed the message that this was play; this was analysis, not life. Our feelings were not to be taken too seriously.

We engaged in a kind of shadow boxing, a metaphor echoed in an observation that Mr. C made at the end of the analysis: "We fought sometimes," he said, "but it wasn't real. We never laid a glove on one another." And looking back over the years, Mr. C captured the essence of the problem that for too long had kept us in place. "We got bogged down," he said, "because neither of us really wanted to move toward the finish line. We had a good thing going for

us and we didn't want it to end. I needed you, and I think that you needed me as well. Isn't that what biologists call symbiosis? Is that a word that analysts use also? If not, they should add it to their vocabulary—it's what can happen in treatment."

Mr. A

A second and closely related factor that may work against the effective use of interpretation and against change in analysis also concerns covert communications on the part of the analyst. In these situations, the analyst's unconsciously experienced and expressed perceptions of the patient serve both to reinforce and intensify the transference and to render ineffectual certain key transference interpretations. A brief clinical example will illustrate the phenomenon that I have in mind.

Some years ago, I was working with a man whose older brother, a brilliant and creative student, I had known very slightly while in high school. Although himself a highly intelligent and gifted person, the patient, Mr. A, felt deeply inferior to his accomplished brother. Mr. A's feelings of inferiority, however, did not diminish his desire to compete with his brother, but rather seemed to increase it.

These complex feelings quickly led to the development of an intense and intensely felt sibling transference, an aspect of Mr. A's psychology that was repeatedly interpreted in the white heat of the moment. There was nothing abstract, nothing intellectual, about these interpretations, or about the patient's spontaneous, confirming responses to them, or about his conviction concerning the truth and importance of the sibling issues that we were engaging. If ever there was a time when interpretation should have been effective in altering a patient's set ideas and beliefs, it was in this phase of my work with Mr. A. The patient became fully engaged in an emotionally charged transference experience that was meaningfully understood and interpreted; by all rights, this should have led to changes in his inner world.

The only problem was that Mr. A had not read our literature, and after two years of what should have been highly productive analytic work, he showed no signs of progress. Still viewing me as the superior, knowledgeable, but condescending older brother who knew everything and talked down to him, Mr. A stiffened and bristled at almost every intervention I made. No matter how mild and unchallenging my interpretations, he responded defensively, often with a sharp retort meant to rebut the point I was making.

Puzzled by the tenacity of Mr. A's reactions, I paid close attention not only to what I said, but also to the way in which I said it—to my tone, manner of speaking, and choice of words, as well as to tact and timing. And, repeatedly, I explored with Mr. A how he had experienced my interventions. Nothing I did, however, altered the picture. Mr. A seemed unable to take in or utilize what I had to say. As a result, the treatment remained at a standstill, and, regretfully, I began to think that this bright and creative man might very well prove to be unanalyzable.

For a while, I entertained the idea that there was a paranoid core in Mr. A that put him on guard and caused him to be ever vigilant, a part of his personality that I clearly had not recognized. This notion, however, did not fit with other aspects of Mr. A's personality, such as his capacity for warmth, caring, and genuine responsiveness to others. I therefore came to believe that we were dealing with unalterable quantitative factors. For whatever reason, I thought, the intensity and fixity of Mr. A's sibling rivalry was such that no significant change in that constellation of feelings and reactions was possible.

I recognized, too, that certain realities complicated Mr. A's experience of me in the transference. The fact that I was Mr. A's brother's age and had known him slightly in school served in the patient's mind to tie me closely to his image of his brother, as did Mr. A's knowledge that I, like his brother, had published papers in my field. These facts made it difficult for Mr. A to take any distance from his perception of me.

As important as these considerations were in contributing to the impasse that developed, they proved to be not as influential as

other, unrecognized factors. Those issues had to do with my view of Mr. A, the picture of his brother that I carried in my mind, some unresolved sibling issues of my own—and, as a consequence of these factors, the kind of communications that I was unconsciously transmitting to Mr. A. It took my spending some time with my younger brother for me to recognize certain similarities, not only in the way that I related to Mr. A and my brother, but in the unspoken attitude that I communicated to each. Indirectly and subtly, more through nonverbal cues than in words, I sought to maintain my place as the older brother, the firstborn son, the one who both younger men (unconsciously both siblings) should, by rights, look up to as more experienced and knowledgeable than they.

It was not that I acted the part of an authority. On the contrary, I diligently avoided that role and made sure to treat my sibling/patient with courtesy and respect. But my attitude, I realized, contained a hint—or perhaps more than a hint—of noblesse oblige: the somewhat self-conscious generosity of someone who, although treating the other as an equal, also conveys the idea that he is, and is to be recognized as, the first among equals.

It was this attitude that all along I had been conveying to Mr. A. And its effects on him were not only to reinforce and intensify an already intense sibling transference, but to give it a stamp of reality that made its interpretation as transference close to impossible. The difference between what I communicated in words and what I communicated nonverbally through unconsciously transmitted cues created a bind for my patient that contributed to his confusion and inability to hear, not to mention trust, what I said.

In my interpretations of the sibling issue, I focused on fantasies, set ideas, and distorted beliefs regarding self and other (me in the transference, and behind me, Mr. A's image of his brother). But the attitude I transmitted reinforced the very beliefs that I was interpreting as creations. For what I conveyed, unconsciously, was the idea that I was in fact the superior one, and that my patient, like my brother, would do well to heed the words of someone older, wiser, and more knowledgeable. And until I could confront myself and my wish to maintain my place, both in our family and in my

relationship with Mr. A, he could not truly engage and work through that part of his response to me that was transferential. Thus, he could not do the essential work of analysis.

Another factor, too, played into the difficulty that we were having. In time, I became aware of the fact that in our sessions, Mr. A's brother was a living presence, not only for him, but for me as well. I realized, in fact, that I continued to be envious of his brother's achievements, a reaction that had its origins in high school some forty years earlier, when I witnessed this remarkable young man carry away almost all of the school honors. While in those years, I had felt hopelessly outclassed by Mr. A's brother, on hearing about him now, I realized that I could be more competitive with him. And without my being aware of it, I believe that in the analysis I vied with the brother—or, more accurately, with my fantasies about him—for Mr. A's admiration. No doubt these efforts colored my interpretations, sent a confusing message to Mr. A, and reinforced his perception of me as his older brother.

Communications on the part of the analyst such as I have outlined are not rare in treatment; in fact, they occur with some frequency. Often unrecognized by patient and analyst, they can be disruptive to the analytic process, and, as a consequence, can block progress and the possibility of change. Of special interest is the effect that these unconscious communications may have on transference and transference interpretations. As happened in the case of Mr. A, while stimulating and intensifying the transference, they can simultaneously create a reality in the relationship between patient and analyst that serves to vitiate transference interpretation. Thus, these unconscious communications may all but eliminate the most effective instrument for change that analysis has to offer.

Mr. L

I turn now to a very different factor that may affect the ability to change. Some patients who have difficulty changing in analysis, I believe, suffer from a covert, often unrecognized phobia that lies concealed beneath their more obvious and noisier resistances. In

many cases, such as in Mr. L, this phobia relates to an early fear of movement—that is, of locomotion—that is unconsciously connected with the idea of change. Quite clearly connected to this fear of movement are profound anxieties over separation from ambivalently cathected caretakers, a problem that, in large measure, relates to the child's fear of his or her urges to destroy an object needed for survival.

Not infrequently, the phobic reaction is not known to the patient, who offers every type of rationalization to explain his or her inability to take action to effect life changes, or even to make decisions. Like Mr. A, such patients may wish to remain in treatment indefinitely. They dread leaving the analyst and equally dread any movement in life.

Renik (1992) described a related problem when he discussed the fetishistic attachment to the analyst that may underlie the failure of certain patients to make progress in treatment. Because it is often quite well concealed, this phobia, which in some cases can be traced to problems in the practicing as well as separation–individuation phases of development, may escape the analyst's notice. Such was the case with Mr. L, an intelligent and gifted young man who, despite his seeming ability to work well in analysis, showed little evidence of progress after several years of treatment. Terrified of his hostility toward and wishes to defeat and destroy an insensitive, boorish father and a priggish and arrogant older brother, Mr. L had taken refuge from his frightening aggression by adopting a passive, noncompetitive attitude, which in essence amounted to a self-castration. These conflicts were actively dealt with in the transference, and Mr. L came to know and experience them quite thoroughly.

In addition, a number of preoedipal issues became apparent and were dealt with both in and out of the transference. It became clear that Mr. L was closely identified with his fearful, pathologically anxious mother, who anticipated and predicted disaster at every turn. When Mr. L was an infant, his mother had become depressed, took to her bed, and for a number of months, was emotionally unavailable to her son. Her withdrawal had the effect of both stimu-

lating Mr. L's rage at his mother and causing him to cling more fiercely to her.

In the transference, Mr. L's long-standing fear of separating from a needed caretaker took the form of his dread of leaving me, ending the analysis, and going out on his own. For this reason, too, he feared making gains in treatment. Such progress, he imagined, would result in his being cast out on the street. These dynamics, too, he came to understand, and armed with this insight, he repeatedly resolved to take steps that would alter his life.

After several years of treatment, however, Mr. L still had not been able to leave the parental home, embark on a career, or establish an intimate relationship with a woman, despite having many female friends. As soon as he began to make a move in life—literally to take a step forward—Mr. L would become anxious, give himself reasons as to why he could not proceed, and retreat to the status quo.

There was, it turned out, another determinant of Mr. L's difficulties that did not surface—or, rather, I did not grasp—for several years. This had to do with the fact that as an infant, Mr. L had developed an orthopedic problem that delayed his learning to walk for a year or more. This physical problem resulted in a fall, as well as a rather serious eye injury when Mr. L did start walking, and seriously compromised his ability to separate and individuate, contributing very significantly to a phobia of locomotion and movement that infused and lent intensity to his fear of change.

Although the evidence had been in front of my eyes from the moment Mr. L lay down on the couch, I did not see it until one rainy day when Mr. L arrived soaking wet, his thoroughly drenched trousers clinging to his skin, and my attention was drawn to his legs. I had been aware of the fact that Mr. L moved very little on the couch and that he lay rather stiffly, but I had not previously noticed the positioning of his legs. Now I observed the way that he held them: fully extended, motionless, perfectly parallel, with his feet remaining a fixed distance of approximately twelve inches apart.

As I observed Mr. L in this manner, a memory from my internship days suddenly came to mind. I recalled seeing several young

children lying in cribs on a pediatric ward, each with their legs held apart by a metal rod affixed to their ankles. As I remembered it, these children were being treated by this means for a congenital hip problem. Prompted by this memory, I inquired if Mr. L had ever had an orthopedic problem. He replied that he was once told that he did, but he remembered nothing about the problem and he had no information as to what the trouble might have been.

It turned out that Mr. L had suffered from a condition similar to the one I remembered seeing, a problem that, from the age of about ten months, required that his legs be held by a brace that rendered them motionless and kept them at a fixed distance apart. Uncovering this piece of Mr. L's history offered no magical key to his difficulties, however, nor did it unlock the door to recovery. Clearly, Mr. L's problems were multidetermined, one factor layered upon another, and it required a great deal more analysis of all the relevant issues, particularly as they appeared in the transference, for him to make significant gains.

But it was also true that uncovering this fact was an important finding—that is, the fact that Mr. L had long suffered from a phobia which had its roots in a problem of locomotion. This problem had retarded his ability to walk and had a profound impact on his development and object relations, particularly on his increased ambivalence toward and attachment to his mother. This finding provided Mr. L with insight into a highly significant and previously unrecognized meaning of his fears. It also clarified for both patient and analyst the fact that this phobic dread, so deeply ingrained in Mr. L's personality, was unlikely to disappear through the achievement of insight alone.

Insight had to be coupled with efforts on Mr. L's part to confront his fears, and with the aid of interpretation and understanding of the unconscious fantasies that fueled these fears, Mr. L had to gradually increase his tolerance for the anxiety that would inevitably accompany any forward movement in life. This process, which Mr. L undertook with considerable courage, could be termed analytic—rather than behavioral—desensitization.

While Mr. L's early history made his case an unusual one, over the years I have come across several patients whose intense resistance to change was, in part, fueled by phobias of a similar kind. Although the sources of such pervasive fears are different in each case, what these patients share is a history of highly significant problems in early childhood involving the act of locomotion, and subsequently the process of separation–individuation. Impacting in decisive ways on later phases of development, such problems not infrequently eventuate in adulthood difficulties quite similar to those that brought Mr. L to treatment. Although it is of great importance to work through the patient's fears of separation from the analyst, as well as the concealed aggressive and retaliatory fantasies often underlying such fears, what may be essential to achieving progress in such cases is to make conscious the infantile phobic element and to engage the patient's long-standing dread of movement.

MEMORY AND ITS USES IN PSYCHOANALYSIS

The final issue that I wish to discuss is that of memory and its uses in analytic work. Recently, the value of recovering and exploring declarative memories—that is, memories of events and experiences that can be called up by conscious effort or uncovered by means of interpretation—has come under attack. Fonagy (1999), for instance, has stated unequivocally that the recovery of memories *as memories* is essentially useless in analysis. Efforts to obtain such material, he maintains, are tantamount to malpractice. The only approach that makes a difference in analysis and the only method leading to change, he holds, is that of identifying and interpreting old patterns, old ways of being and relating in the analytic situation. Only in this way, by locating, naming, and gaining insight into such automatic patterns as they emerge in sessions, particularly in the transference, can they be modified. Unlike Freud (1893), who believed that neurotics and perhaps all of us suffer from

the effects of unconscious memories, Fonagy gave short shrift to this part of the memory system.

Fonagy's explication of the way in which transference repetitions are closely related to procedural memory, and the way that interpretation of such repetitions can alter and shift that form of memory, is a valuable one, and in fact this perspective may help us better understand the process of working through and the way in which change takes place in analysis. Nevertheless, I believe that his criticism of memory as such is more pertinent to the intellectual—and frequently ineffectual—way in which we analysts often deal with memories, than it is to the larger issue of the value of recovered memories in analytic work.

This problematic way of dealing with memories can occur, for example, when, as often happens, we seek to help our patients bridge past and present by connecting a current experience with one in the past that we believe to be unconsciously linked to it. While at times this approach can be useful, all too often it achieves at best a cognitive understanding, which, not infrequently, is then defensively employed. This is very different from earned memories, emotional memories evoked by the moment, that are wrenched from the gut—the kind of memories that, early on in the history of analysis, Freud spoke of when he referred to the therapeutic value not merely of memories, but of *affective* memories.

There is an enormous difference between remembering, and remembering that makes a difference—the kind of memory that begins to unlock the psyche and its creations. In this connection, author and mountaineer Jan Krakauer (1998) quotes the trenchant views of fellow writer Harold Brodkey:

> I distrust summaries . . . any kind of gliding through time, any too great claim that one is in control of what one recounts; I think someone who claims to understand but is obviously calm, someone who claims to write or speak with emotion recollected in tranquility is a fool and a liar. To understand is to tremble. To recollect is to re-enter and be riven. I admire the authority of being on one's knees in front of the event. [p. 283]

It is this kind of remembering, this kind of meaningful immersion in the experiences of the past as the mind has processed and re-created them, which I believe many of our current techniques have short-circuited, and by doing so, have effectively blocked an important aspect of the working-through process that is so necessary for the forging of change.

If an emotionally charged moment in analysis sets off a train of meaningful associations and memories that bring an experience of the past alive so that truly affective reliving takes place, that is one thing; such experiences can begin to untie knots, dismantle densely woven patterns, and open the mind to the fresh visions offered by interpretation. But more often—I would say usually—this does not take place because there are powerful resistances against this kind of remembering. What happens instead is that the transference moment produces understanding—recognition—that a connection between past and present exists. This, however, is thin memory, washed-out memory; summary, not substance; not the dense, rich, *felt* memory that can make a difference.

"This is the way it must have been when I misinterpreted my father's behavior and thought that his neglect of me was my fault," says the patient who senses that her anger at me for missing some sessions is related to old angers and the irrational feelings of self-blame that accompanied them.

"Now I see how enraged I must have been at my sister," says the patient who is in a fury because she believes that I favor another female patient over her. There is insight here; there is some understanding—possibly useful understanding. But there is defense, too, protection against true remembering. And all too often, I find, this all-important defense is not sufficiently engaged in treatment or emphasized in our current approaches.

Sometimes, of course, the patient's resistances are so formidable that no breaching of them is possible. At other times, however, it is the analyst who, along with the patient, avoids memory; for as Blum (1980) pointed out some years ago, evocation of the analyst's past, including the return of a host of memories that he or she does not wish to encounter, are inevitably stirred by the rousing of the

patient's ghosts. And this is not always a welcome experience for the analyst. Equally important, I think, is the fact that some modern theories and the techniques derived from them do not recognize the value or importance of recovering the living past in the form of memory. Everything essential, we are told, is encompassed in the here and now of the analytic moment. There is, of course, much truth in this assertion, but it also omits a critical element in dealing effectively with transference.

The understanding of transference is of value not only as a means of gaining insight into long-standing behavioral patterns and patterns of defense, but as a way of accessing those pathological fantasies and beliefs encoded in memory. Analytic work in the here and now, in other words, can be most effective and has the greatest mutative potential when it is linked to the past in a special way—when the past arises with freshness and vividness, when one can relive and be riven by the past as it is triggered by the transference moment. Otherwise, one of the analyst's tasks is to engage the defenses, those ubiquitous defenses, against the kind of affective reliving that Freud spoke about so many years ago.

In what follows, I will present one more clinical example. I cite it because I think that it illustrates my belief that the therapeutic action of psychoanalysis—the action that leads to change—can be viewed as operating on two levels. The first puts patients in touch with their characteristic defenses, the unconscious motives for them, and their accustomed ways of being and relating in the world. Through insight, patients make contact with unconscious fantasies and procedures, both intrapsychic and relational, which they have utilized to adapt to inner and outer realities, to provide safety, to avoid pain, and to obtain as much pleasure as possible. Clearly, this is essential work, and for the many patients whose analytic experience is engaged solely or primarily at this level, significant gains may be, and frequently are, achieved.

Much of the pain that patients seek to avoid, however, is contained in psychological experiences and their private meanings, as they exist locked in heavily guarded memories. And it is only through gaining access to and effectively reengaging the psycho-

logical experiences encased in such memories that a deeper level of therapeutic action can take place; this is the level at which the most meaningful and effective working through is accomplished. Despite their strength, in time and with persistent analysis, the defenses that protect such core memories may ultimately soften and give way. Then the patient may come in touch with these memories and may begin to explore those fantasies and distorted beliefs contained within them that have contributed so much to his or her suffering.

Mr. D

Sometimes, as I have noted, the patient's access to past creations depends on the analyst's awareness of, and ability to confront and overcome, his or her own avoidance of memory, the reluctance to recognize and reexperience those troubling memories that the analyst has unconsciously attempted to keep at bay—memories that, inevitably, will arise as those of the patient begin to emerge. This was a factor in the analysis of Mr. D, a man I worked with some years ago and whose treatment taught me many lessons.

When I first met him, Mr. D was an author who could no longer write. For two years, he had been working on a memoir, but found himself writing and rewriting the same passages. He could neither move ahead nor drop the project to start something else. He thought about trying to jump-start his career by writing a children's book—years before, he had written a very popular one—but could think of no appropriate tale to tell.

Increasingly, month by month, Mr. D had become more depressed, so that now he found it difficult to get out of bed and get dressed in the morning. His troubles, he said, began when the magazine for which he had written for many years was sold. The new editor did not approve of Mr. D's style, which he found old-fashioned, and had rejected a long article that he had worked on for over a year.

In treatment, the patient railed for months against his employer's new regime, detailing every fault, flaw, and foible of the miscreants who had used him badly. Only incidentally and in passing did

he mention the occurrence, two years earlier, of several significant events. Mr. D had undergone surgery for an abdominal condition, his daughter had given birth to a stillborn child, and as a consequence, his wife had become seriously depressed. My efforts to learn more about these experiences met with strong opposition. Mr. D denied their relevance to his present problems and maintained that he had handled them without difficulty. He all but refused to talk about them, and for reasons that I later came to understand, for some time I did not pursue these matters further.

For many months, my work with Mr. D consisted of the exploration of the apparent source of his depression: the terror that his power as an artist—and also, more recently, his power as a sexual man—might be failing. We undertook a painstaking analysis of his characteristic ways of protecting himself against these threats.

One of his main defenses was to focus on the shortcomings of others. Despite his depression, Mr. D remained a good storyteller, and for many hours he attempted to escape his own problems by relating stories that illustrated the blindness and ineptitude of the jackasses who now ran the magazine for which he worked. It took much doing for Mr. D to begin to recognize the envy, rivalry, and feelings of despair that lay beneath his vitriolic attacks. Gradually, however, he came in touch with the affects and fantasies that motivated his endless, almost paranoid assaults on his enemies. As for the transference, I perceived a growing dependency on me, resentment of my (then) comparative youth, and a yearning for a close bond with me as the son and brother that Mr. D had never had.

None of this could Mr. D talk about. With remarkable tenacity, he avoided any thoughts about—even so much as a reference to—the analyst; nor, when questioned directly, did he acknowledge having any feelings whatsoever about me. I was an analyst, a workmanlike, probably competent one—he would give me that—but that was it. For quite some time, all my efforts to work with the resistances that kept the patient's feelings about me out of awareness came to naught.

In the analytic hours, we talked of many things. Intuitively, I sensed that with his underlying fragility and feelings of terror, Mr.

D needed to feel my presence and support, but despite my being an active participant in the sessions—someone whom he had to bump up against five days a week—Mr. D continued to be unaware of having any emotional response, save an occasional feeling of annoyance, to anything I said or did.

As it happened, during one summer break, I injured my leg in an accident and returned to work limping and in obvious discomfort. Although he clearly noticed my condition, Mr. D said nothing about it. After several days of his ignoring me in this way, and propelled, no doubt, by a wish for recognition of my stoicism in continuing to show up every day despite being in pain (rather like a gutsy quarterback who plays while hurt), I called Mr. D's attention to his oversight.

He *had* noticed my condition, Mr. D replied, but he had nothing to say about it. Obviously, I had injured my leg, but so what? Even for a shrink who no doubt hated the sight of blood, that must be no big deal. And very frankly, he added with a note of sarcasm, he had other things on his mind.

Something about Mr. D's indifference got to me, and I found myself responding impulsively. "Listen," I said, "I think something else is going on here. This is not simply a matter of your being preoccupied with other things. This is more purposeful. If you visited a frog five times a week for over a year and he got hurt and suddenly showed up lame, you'd have some feelings about him."

How such an example came out of my mouth, I had not the foggiest—nor the froggiest—notion. Only much later did I realize that Mr. D had had an idea for a children's book involving a frog, one that reminded him of a valued pet he had kept for some time as a child.

Mr. D remained silent for a moment before speaking. "Well, now that you put it that way, I get your point," he said, in his most sardonic manner. "I haven't been able to acknowledge it, but seeing you in this condition *has* affected me. It really chokes me up. But the frog idea is stretching things; that's your self-serving distortion. A toad would be a lot more accurate, more in keeping with the personality and the profile."

Now, I do not believe in the idea of breakthroughs in treatment. I have always believed that a so-called breakthrough is actually the result of a lot of knocking at the door, a lot of grunt work, and a lot of unraveling of knots. But if anything like a breakthrough occurred in Mr. D's treatment, this was it. The humor, the fellowship, the sharing of a laugh, the expression of affectionate feelings, disguised though they were—all this seemed to promote an easing of Mr. D's defensive posture, a lowering of his protections.

From that point on, Mr. D was more open in revealing himself, including thoughts of ending his life in the event that he could no longer write. He also spoke more openly about me, and admitted for the first time that he had read a book I wrote. Clearly restraining himself, he was only mildly critical of my redundant style, and in fact acknowledged that for an amateur writer (the implied comparison with himself was evident), I had described case material reasonably well. About the content of the book, Mr. D said nothing.

Although he was less guarded and self-protective, Mr. D's defenses, centering mostly on intellectualization in one form or another, were formidable, and for many months, the analytic work focused on the here-and-now analysis of the infinite variety of defensive moves and operations that he utilized. Some of these were directed against threatening affects, some against recognition of Mr. D's growing dependence on and need for me, and some against the emergence of painful memories. For the longest time, the patient did not speak about the past; for him, the past was gone and forgotten. He remembered practically nothing of his childhood, save very isolated memories, such as having the pet frog for a number of months. Moreover, he did not want to remember. He saw no point in stirring embers. Digging around in the past seemed to him a messy and useless undertaking, one that could only cause trouble.

Despite Mr. D's strong wish to keep the past buried and out of sight, as his trust increased and his anxiety diminished, he began to talk a bit about his childhood. What I got to see then were snapshots, isolated pictures of a boy growing up on a farm with a reticent, ungainly, and essentially uncommunicative father and a mother who struggled with quite severe depressions. For a long stretch of

time, his mother had been withdrawn and unavailable to her son. Mr. D spoke of the pervasive feeling of isolation that he often experienced, and noted that, in his loneliness, reading—and later, writing—became ways of expanding his world. At first, he spoke hesitantly and carefully about the past, and as it turned out, left out much. What was apparent, too, was that Mr. D's initial memories contained little affect. It took some time, the growth of a good deal more trust in me, and much persistent analysis of my patient's defensive avoidance of reexperiencing what was in fact an enormously painful childhood—before he could reenter that world in a way that ultimately made a difference.

Despite these limitations, however, there were substantial gains from the work we did in those first two years of treatment. Largely because he came in touch with his own struggles, Mr. D's tendency to project his own conflicts onto, and to attack, his colleagues diminished, as did his testy harshness and bitterly critical attitudes. He became more tolerant and more understanding of others, and in return, began to receive more positive feedback from his family and friends.

All of this helped Mr. D's depression, to some extent, but because it was so closely linked to his ability to write—and to other factors that I did not then understand—it remained a weighty stone around his neck, one that threatened still to pull him under. Almost daily, Mr. D returned to his desk, labored diligently, but achieved very little. Despite his best efforts, he could not move ahead on his project, and after close to two years of treatment, still had published no new work.

One day, Mr. D spotted me sitting at the counter of a coffee shop near my office. Unbeknownst to me, he stood at the entrance observing me for some minutes. Then he left, and only days later did he bring up the incident. When he did, he spoke hesitantly of the impression he had had that something was troubling me. From a distance at least, I seemed preoccupied, lost in my own thoughts, perhaps worried, or was I perturbed by some unhappiness in my life? He sometimes thought of me as struggling against some great weight that I carried around. Then, with much reluctance, Mr. D

revealed that certain passages in my book had upset him a lot. From my writing, he got the impression that I must have suffered a very painful loss in my life. This idea bothered him; it made him very sad, and the thought had stayed in his mind ever since he came to the conclusion that this might have happened. He hoped that he was wrong, but in any case, he would like to know the truth.

After a moment in which I said nothing, Mr. D went on to discuss other topics. He did not return to this subject, and I did not pursue it; nor in the following days did I explore Mr. D's reaction to what he had seen or read, or interpret his avoidance of a matter that clearly had a great deal of meaning for him—and for me. It did not take long, in fact, for me to realize what had happened. Out of my need to avoid memories of my own, memories that inevitably brought with them the painful reexperiencing of the loss that Mr. D had alluded to, I colluded with him in avoiding the subject. And as long as I did so, Mr. D could avoid the evocation of certain memories of his own—memories involving grief and loss, which had been initially stirred by certain passages in my book, and then more forcefully by his observation of me in the coffee shop.

Realizing that I could no longer avoid the issue, when the timing seemed right, I returned to the topic of what Mr. D had read and seen, and explored with him his reluctance to speak openly about these experiences. Slowly, over the next few days, the patient began to talk about what he imagined had occurred in my family. As he did so, memories of his own surfaced, and the long-forgotten world of his childhood began to emerge—a childhood that involved a profound loss of which Mr. D had never spoken to anyone, a loss that for years had been carried around like a stone in his heart.

Mr. D's four-year-old sister had died when he was eight, a sudden, totally unexpected death that triggered a profound depression in Mr. D's mother—a depression so pervasive, in fact, that it left the boy without a mother. Devastated by these losses, Mr. D's father withdrew into a state of apathy, and without parents or a sibling, Mr. D, too, retreated into a world of solitude and daydreams. This retreat into a protected shell was made more pronounced when, at age ten, Mr. D had to undergo emergency surgery for a ruptured

appendix, and following this, he was all but abandoned in the hospital. It was at this time that Mr. D first began to write. Sitting alone in his bedroom, he would make up stories about animals who sought and found new families in the circus, in the zoo, and in county fairs.

Mr. D's isolation lasted for several years, and it was only in college, when he met a young woman who took an interest in him and encouraged his talent, that he began to emerge from the shadows. With the luck of Job, however, the patient lost this woman, too; while driving on wet roads one night, she had a head-on collision with a truck and was killed instantly.

It took many years for Mr. D to begin to recover from these experiences, and this he did primarily by burying them. This was a deliberate, as well as an unconscious, process, and the patient never spoke with anyone about his childhood experiences. Nor did he share with anyone his feelings about more recent difficulties, including his operation and the stillbirth of his grandchild, both of which, despite his efforts at avoidance, began to stir memories. And when Mr. D attempted to write a literary memoir, an unconscious effort, I believe, to come to terms with his past and with an increase in pressing memories, his inability to either contain or tolerate these memories (for he was not yet ready to do so) led to the almost total paralysis that brought him to treatment.

Once the locked doors of memory began to open and Mr. D began to speak about his childhood, for some weeks, he could do little else. The hours were filled with recollections remembered not in tranquility, but with hellish pain and searing intensity. At one point, when Mr. D spoke of his sister's death, his mother's grief, and his own profound loneliness, this rigidly protected man—a man who had for years revealed none of his feelings to anyone—broke down into tears and wept for fully five minutes.

For some time during this period, I was primarily a listener, a sharer of memory, a witness to a past recollected in anguish. But gradually, it became possible to intervene and to explore with Mr. D not only the way in which his childhood experiences had become registered in his mind, but also how they had been created. We

looked at the way in which his confusion, rage, and guilt, together with his imagination, had produced a set of fantasies and beliefs that contained distorted views of himself and others. Central among these fantasies was Mr. D's conviction that he was a bad seed, a child whose birth, whose very existence, had brought on unspeakable tragedies.

As Mr. D relived and reworked his memories and his creations, he began to plan a new writing project. Not yet feeling ready to return to the memoir, he decided instead to resume his writing by working on the children's book that he had previously mentioned. This story was to be about a frog who is inadvertently transported to the city with a farmer's produce, gets lost in Manhattan, and takes up residence in one of the vest-pocket gardens that dot the city. A callous real estate developer wants to destroy the garden to make way for a new office building. Joining forces, a group of neighbors battle the developer, manage to defeat him, and save the frog's new home—or something like that.

In one session, during the time that Mr. D was discussing this new project, he reported a short dream. It contained a single image: that of a frog sitting among colorful, blooming flowers. "I think that's me," Mr. D said, "by way of associations. I am the creature in the garden. The garden relates to my book, to my blooming and coming alive again. But you know, I think that the frog is also you. It's a combination of the two of us; you've been in the garden, too. In your own way, you've been in there digging and planting, trying to preserve it, trying to make it grow. And say, did you notice that I've upgraded you in the dream? The toad has become a frog! He's come up in the world. I guess my unconscious is speaking for me, even if I can't talk about my feelings."

At that moment, a strange and quite incomprehensible image arose in my mind. It was that of an old woman, sitting on a chair beside a table radio—a 1940s, oval-shaped, Philco model, the kind that we had in our apartment when I was growing up. The woman was looking out the window at a big concrete stadium of some kind. I had not the slightest idea where this image came

from, what it signified, or what to make of it. And, unable to decipher it, I let it pass and focused on other matters.

Then, while I was driving home that night, a line of poetry surfaced in my mind, one that I had not thought about in decades: "Imaginary gardens with real toads in them." And I knew then who the figure looking out the window was: Marianne Moore, the poet and avid Brooklyn Dodgers fan, a woman with whom, in my youth, I had been totally in love. And the stadium she was looking at was Ebbetts Field, where as an aspiring sportswriter, I had traveled by subway to cover the Dodgers' games. The line that had surfaced was, in fact, Moore's definition of poetry (Nelson 2000), an art form that is forged out of—and connects—the real and the imaginary, perception and illusion, history and memory, the image and the object, gardens of the imagination with living and breathing creatures in them.

While sitting in my car, headed north to the Willis Avenue Bridge and home, I found myself thinking about the day's events, about the hour with Mr. D, and about the strange image that had appeared in my mind. And I thought again of Marianne Moore and how much she had understood not only about poetry, but also about human nature. And again I reflected on her definition of poetry: "Imaginary gardens with real toads in them." It was remarkably astute, I thought, and not a bad way to define analysis as well. Isn't that what it is really all about, the analytic situation, the art of analysis? Isn't that what we have come to understand, not only from the new, but from the new joined with the old? Isn't analysis based on two real people who are deeply involved with one another, each experiencing and constructing the other, dealing with moments past and present, stirring memories and using those memories to recover experiences lived and created—two gardeners digging in gardens, real and imagined?

"Imaginary gardens with real toads in them." Toads who, if they work hard and hang in there long enough, may yet get upgraded to the status of frogs. It is a tough business we are in, I thought as I headed across the bridge, but there are rewards. There are some pretty good days as well.

CONCLUSION

What then, in summary, I have attempted to say in this paper is that for me, the goals of analysis must include the use of the analytic process to produce meaningful change in a patient's life. For many individuals, however, such change is hard won, and despite our modern knowledge and techniques, for not a few patients, progress of that kind may seem to be unobtainable. In such situations, the analyst may be tempted to resort to explorations rooted in biology, or to the idea of bedrock, immovable resistances. At these times, it behooves the analyst to review the treatment and to look again at a number of key factors: the patient's history; covert aspects of the analyst's countertransference; the kind of messages that, unconsciously, the analyst may have communicated to the patient; and the extent to which affectively rich memories have surfaced, and the fantasies contained within them interpreted and worked through.

For it is in these areas that well-concealed and previously unrecognized resistances may reside. Once uncovered and identified as being a primary cause of stalemates and feelings of hopelessness in patient and analyst, such covert resistances, as well as the conflicts and fantasies that underlie them, can often be effectively engaged and analyzed. And when that happens, the change which patient and analyst together have sought to achieve may begin to take place—change that involves not only the interior life of imagination and fantasy, but the patient's way of being and living in the world as well.

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Psychoanalytic Quarterly, LXX, 2001

NO SEARCH OR GETTING DOWN TO BUSINESS?

BY STEPHEN A. MITCHELL, PH.D.

Pretty much from the beginning, from my days in psychoanalytic training, I found myself thinking about goals in psychoanalysis along two different, seemingly contradictory lines. They have a complex relationship to each other, and each has undergone some changes and development over the years.

THE "NO-SEARCH" CONCEPT

The first approach is an adaptation of the "classical" mode of psychoanalysis, as I came to understand it. An essential property of psychoanalysis as a treatment has always been that it is "nondirective," a quality that distinguishes it from other types of therapies which, in their focal directedness, are more limited. It was thought crucial that the analyst not interfere with the freedom of the patient's free associations, so that the latter's central unconscious conflicts might manifest themselves through derivatives. This noninterference, which makes analysis "deeper" than other treatments, was ultimately a means to an end. The end was the exposure, interpretation, and finally the transformation of specific, central yet unconscious, infantile sexual and aggressive conflicts at their major points of fixation.

This paper is adapted from presentations on two panels at Division 39 conferences to which the author was invited: in April 1999 (New York) and in April 2000 (San Francisco).

But to arrive at the ultimate destination, the classical analytic dyad needed to give up any focal search, any interest in symptom relief, any conscious business or preoccupations, in order to allow the unconscious derivatives to bubble up to the surface. In my understanding of the classical model, when it comes to unconscious wishes and defenses, specificity is very important; they need to be interpreted in just the right way. I always thought of Glover's (1931) paper on inexact interpretation as the ultimate expression of this sensibility: you have to interpret the repressed absolutely correctly, getting the configuration of wishes and defenses just right; inexact interpretations actually serve the resistance by allowing the patient to cop a plea to a different offense. Glover seemed to be saying, along with Eldridge Cleaver, that if you are not part of the solution, you are part of the problem.

My own practice of psychoanalysis has both appropriated and also reacted against this central feature of the classical model in two different, almost opposite ways. First, I have appropriated the methodology of nondirectedness, but linked it to a different set of implicit goals. This is because I believe that the basic meaning of *the unconscious* has shifted markedly in postclassical analysis. In the classical model, there was specific content to get to. The now-anachronistic concept of a "complete" analysis suggested that any given analytic work could be measured as more or less complete with respect to how much of that content had been reached: the different fixation points, the different psychosexual levels, and so forth.

In postclassical analysis, as I have come to understand it, unconsciousness refers less to specific content to be uncovered than to a kind of experience to be opened up, a capacity for a certain responsiveness to oneself that is to be cultivated. This idea is most clearly developed in Loewald's work. Normative psychopathology, for Loewald (1980), entails, most fundamentally, a split between a generally conscious, secondary process mode of organizing experience (based on differentiations into self and others, now and then, internal and external) and a primary process mode of organizing experience (characterized by affective density, timelessness, and fantasy). What analysis is about, according to Loewald, is relinking these two

modes or organizations of experience. In this approach, the meaning of the term *fantasy* has shifted from a compensatory, defensive reaction to frustration, as in Freud's term "hallucinatory wish-fulfillment," to a fundamental mode through which the mind generates experience, much closer to what we might call *imagination.* (This shift is to be found as well in the Kleinian distinction of phantasy versus fantasy.) Thus, for Loewald, consciousness and its contemporary objects need links to the affective density of the unconscious, without which "human life becomes sterile and an empty shell" (1980, pp. 250-251).

Loewald's desired state of a more open, interpenetrating exchange between primary and secondary process levels of organization is closely related to Winnicott's (1958) ideas of "going on being" and "transitional experiencing," certain states of mind cultivated by Eastern forms of meditation. These states were discussed by Epstein (1995) in terms of "bare attention" and watchful attentiveness, and also in Ogden's (1997) description of the state of mind generated by reading poetry, a state that he likened to "reverie" in psychoanalysis, where the rich, sensual density of the process is an end in itself.

How can the analyst effectively help the analysand arrive at such an enrichment of experience? Most analysands present themselves with a sense of where they need to go: they are imprisoned, thwarted by obstacles, and they want us to try to help them escape and overcome their obstacles. But Schafer (1983), in his depiction of the "imprisoned analysand" (p. 257), and Phillips (1993), in his discussion of what he ironically called "obstacle–relations" (p. 89), suggested that central to the analytic process is the analysand's acceptance of his or her own role in the devoted construction of the very prisons and obstacles from which the analysand longs to be free. If he or she stops making goal-directed efforts at escape, the analysand may then become more aware of his or her stake in prison-building.

Thus, one role I envision for myself is that of encouraging the analysand to give up goals in the analytic situation—and, episodically, in his or her life in general. It is here that the classical methodology of nondirectiveness is employed for a different purpose: not

as a means of arriving at specific, unconscious conflicts, but as the cultivation of a mode of experience less driven by secondary process concerns (such as effectiveness, productivity, and performance), and instead more open to affective currents, fantasy, and imagination.

This methodology might be characterized by the Taoist notion of "no search" as the most likely path to enlightenment. Searching for enlightenment through effortful focus is, as Chuang Tze said, like "searching for a fugitive with a big drum" (Ballou 1939, p. 533). Or, as Lao Tzu said, "To seek learning one gains day by day; to seek the Tao one loses day by day . . . . Do nothing and yet there is nothing that is not done" (DeBary et. al 1960, p. 61). Do less, not more. Do not add projects, but rather become more aware of those unconscious projects, that prison- and obstacle-building that you are habitually involved in; in letting go of those, there is an opening into new and richer experiences. Thus, in this line of thought, the classical method of nondirectiveness still works, but it has become linked to a different ultimate goal.

GETTING DOWN TO BUSINESS

The second line of thought that runs through my work with respect to the issue of goals is very different from the no-search approach. It begins for me with the impact of Sullivan's (1953) notion that people seek us out because of their "difficulties in living," with which, he argued, we are obliged to be helpful. In this approach, which developed in part as a counterideal to the classical principle of nondirectiveness, and partly as a reflection of the more pragmatic sensibility that pervades American culture, there is a sense that life is short, inhibitions in living are wasteful, and that change is often possible. There is in this attitude an antidote to the sense of tragedy and fatalism cultivated over the centuries in war-torn Europe, which shaped Freud's psychoanalytic sensibility.

Classical wisdom, based on closed-system energics, had it that we should not focus on symptoms because underlying conflicts would

soon generate replacement symptoms. This was just wrong. Some symptoms and inhibitions are painful impediments to living and sources of humiliation, and removing them can often open up whole domains of experience that were not hitherto available. Sullivan believed that sometimes insight follows change, rather than the other way around. Different choices and different behaviors sometimes make available different experiences, which then make possible new insights. It is very interesting that this sensibility of Sullivan's has resurfaced in different places in recent analytic literature, including in San Francisco, where Renik (1998) emphasized "getting real" in analysis, and Bader (1998) argued for the analyst's acceptance of the role of change agent. Another example is the argument by infant research groups that insight often follows changes, in what these researchers call "implicit relational knowing" (Stern et. al 1998, p. 903).

It has long seemed important to me that an analytic approach which concerns itself with behaviors and symptoms should be combined with a thoughtfulness about the communicative and expressive value of certain symptoms. I was a candidate in the days in which there was a lot of excitement about sex therapy and its efficacy in curing sexual dysfunction of various types. Some of my teachers spoke enthusiastically of combining sex therapy techniques with analytic work. One, however, who had been trained by Erich Fromm and had picked up from him a great emphasis on the issue of authenticity, argued that sex therapy was destructive, because sexual dysfunction was often the most honest thing about certain patients. For a male patient who dissembles and lies in all his relations with others, for example, impotence might be the clearest expression of his rage and revulsion; and removing the symptom behaviorally, therefore, is simply helping him to be a more effective liar.

I spent a lot of time thinking about this argument and still do. Inquiry has remained the central feature of the analytic experience for me. But ultimately, symptoms like impotence are a continual assault on self-esteem; help in removing them is likely to be quite constructive. Issues like authenticity and falseness do not require symptoms like sexual dysfunction as their only point of analytic access.

This "getting-down-to-business" approach endorses the classical notion that psychoanalysis ought to be concerned with exploring and transforming specific, deeply conflictual experiences, but rejects the methodology of nondirectiveness as the best route to getting there. In this aspect of my work, I often become involved in particular, disturbing features of the analysand's life—in problems and constrictions in his or her relationships with other people, for example. These extratransference relationships, as well our relationship with each other, become important content to explore and work on. I sometimes suggest "thought experiments": What if you tried this? What stops you, in that sort of situation, from saying something like that? The point is not the offering of actual suggestions, although sometimes patients take them up precisely as that. The point is to stretch the imagination. Much more often, as patients think their way into what I am suggesting, they find that such questions strike them as preposterous, or lunatic, or exceedingly dangerous. And then it is very useful, in a characteristically analytic fashion, to explore why that would be.

Simple advice giving by analysts almost never works. But the phobic attitude toward advice giving, derived from the ideal of nondirectiveness, forecloses all sorts of very useful experiences between analyst and analysand around their obstacles to being helped and helping themselves.

One of my most vivid and fondest memories of professional analytic meetings took place a few years after I graduated. The speaker was a guest from another institute who was known for bending usual analytic techniques. He discussed giving advice to patients, which he defended as sometimes useful. It caused quite a stir. One by one, the senior analysts of the institute, whom I knew from personal and secondhand experience to be quite free themselves in offering advice to anyone who would listen, including patients, rose to condemn this heretical idea as shockingly incompatible with true analysis, as a crude manipulation of the patient by misusing the analyst's influence. The speaker was getting creamed and had trouble defending himself. A hand went up in the back of the room, and a lowly candidate said something like the following.

"I don't really understand why advice giving is so dangerous. I mean, I'm trying to think about how giving advice works in my life and to whom I give it. I give advice to my wife, my kids, my friends, and *no one listens to my advice!* I really don't understand why we need to be so afraid that patients will be damaged by our powerful influence." I had the sense that rarely since the emperor strode out in his new clothes had so much pomposity been so rapidly deflated.

THREE VIGNETTES

The "let's-get-down-to-business" approach seems to conflict with the "no-search" approach. But in practice, they actually facilitate each other. I will now turn to three brief, greatly reductive clinical vignettes, one from the beginning of a treatment, one from somewhere in the middle, and one toward the end of a treatment, to explore how that might be.

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Otto, a fortyish man of European extraction, arrived at my office in considerable distress. His marriage was in a state of desperate collapse, and he had been remanded to therapy by an ultimatum from his wife. Otto lived in a state of what sounded to me like extreme crankiness, hypercritical of both himself and his wife. Sex had been gradually vanishing from their relationship for years, mostly on his account, and had been nonexistent since the birth of their first child eighteen months before. Otto felt himself to be a total failure as a husband and as a man. He'd been in therapy several times before, but to no avail. He would do what he felt he was supposed to do as a patient, become gradually disaffected and disapproving of the therapist, and then leave.

Here are some of the dynamics, as we came to understand them. Otto was the only child of a racially mixed couple living in London. Otto's father was distant, depressed, and alcoholic. His mother was intense, paranoid, demanding, and extremely involved with him. He grew up in a claustrophobic, paranoid world in which he felt

himself to be, inevitably, a profound disappointment and failure. His life's work was to simulate normality—as a son, as representative of his family, and now as a husband, lover, and father. Although extremely conscientious, he found that all this effort felt futile and exhausting. His few joyful memories from childhood involved moments of freedom in solitude, like riding his bike at night under the stars. Sexuality had early on become harnessed into the service of pleasing others. Otto's first lovers were older women who, in his experience, easily felt unloved, and required continual reassurance through his attentions, sexual and otherwise. His wife had had earlier severe sexual traumas, and thus their sexual relations were fraught from the beginning with mutual anxiety and a focus on reassuring her.

Otto was quite desperate and wanted some sort of programmatic help from me to make his marriage better. I encouraged exploration of the labored, conscientious way he approached therapy and the role that his stance played in the collapse of his previous treatments. Yet trying to help him relieve some of the intense pressure of the situation seemed important and reasonable, and I settled into what might be considered a countertransferential posture of offering advice. Over the course of much detailed inquiry, I pointed out to him how much his interactions with his wife were structured around his focus on what he felt to be her expectations and demands, his compliant efforts to satisfy them, and his covert and very angry defiance of them. I encouraged him to stay with—even during our sessions—what *he* felt and wanted, which was very hard for him to allow himself to do.

Otto became quite intrigued with how much his life was organized around externality and how self-defeating that necessarily was. Sexuality was a service which he felt bound to provide. Any intimacy quickly became refocused onto what he thought he was expected to do next, which of course killed the excitement. And in the tedious, burdensome life he and his wife had coconstructed for themselves, experiences of excitement rarely emerged. Not surprisingly, Otto's relationship with his work had much the same structure: a constant pressure to meet the expectations of others and a

continual sense of deadening in relation to his own creativity and vitality.

I conveyed to Otto some basic principles of sex therapy and its programmatic efforts to suspend performance anxiety. Otto wanted to *have had* sex with his wife more than he wanted to *have* sex with his wife, because he experienced the route to sex with her as exceedingly difficult, a "huge mountain," the traversing of which would require enormous effort. I noted that as soon as he established the mountain between them, the possibility of sexual desire was gone. Here was this woman whom he had once found attractive, possibly available for pleasure. I wondered what would happen if he stopped trying so hard, if he did less rather than more. There actually was no mountain, I suggested, except the one he unconsciously worked so hard to imagine. I asked him to consider whether or not he actually wanted the mountain, on whose slopes he so arduously toiled, to exist. I wondered what might be problematic about an effort to set up some times for Otto and his wife to talk and be together physically, without any expectations about what would happen. We talked about this not-very-veiled suggestion of mine, his eagerness to comply, his fear of further pressure on him, and so on.

After a few weeks, he did set up times for them to engage each other. He came to the next session with reports of sexual play between them. (He was now conscientiously working on the slopes of his analysis instead of his marriage.) There were some initial dramatic results, mutually tearful and sympathetic revelations of their struggles with their own lives and each other. There was physical intimacy for the first time in months. These encounters allowed Otto and me much greater access to the phenomenology of his automatic eclipsing of his own desire. Excitement and pleasure themselves, we learned, made him very anxious; these emotions seemed selfish and almost cruel, in that they distracted his attentions from the other. For the first time ever in the presence of another, he was able to begin to allow himself moments of self-absorbed pleasure—a Winnicottian moment of "going on being," which might serve as the ground from which a genuine sexual impulse could emerge.

The rhythm of my work with Otto reflected a focused undertaking of efforts to help and make things better, alternating with stretches of what he described as increasingly comfortable "emptiness," or states without focused projects or self-measurements, and also dead periods in which he felt hopeless. Explorations of the hopelessness sometimes reflected his having slipped into compliance with what he took to be the expectations of his wife, his boss, or me. We came to regard his hopelessness not as backsliding (as he had previously regarded it) or failure, but as an important signal to both of us that he was no longer with the project he had previously helped design, that something else was going on which was important and needed to be looked into.

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Becky,[1] a 30-year-old woman in the fifth year of intense and productive analytic work, had begun analysis in a state of considerable confusion and drift, both in her personal relationships and in her career. She had had a difficult childhood in many respects. Her mother was a college professor who considered herself a failed scholar and was quite depressed; she regarded any successes on Becky's part as a profound threat. Her father, a corporate executive, was a lively, flirtatious man who had had open affairs with considerably younger women during Becky's adolescence. During her teenage years, there had been an intense, seductive tension between the two of them, about which she felt intensely ambivalent and guilty. "Your body is just the same as your mother's was when I fell in love with her" was the sort of thing he would say to Becky, in the context of discussing the death of his sexual relationship with her mother. Becky experienced both parents as extremely self-absorbed and concerned only about appearances, oblivious of her inner life.

Over the course of our work together, Becky had returned to school and was pursuing an advanced degree in history. She ex-

[1] Elsewhere, I have described my work with Becky from another point of view (Mitchell 2000, pp. 70-75).

pressed considerable anger at me. I had been missing how much trouble she was having, she claimed. Perhaps I was misled by her apparent success at school, not noticing how depressed and anxious she often felt about how blocked she was in the papers she was supposed to be writing. Perhaps, like her parents, I was more interested in appearances and my own values than in her inner experience or in helping her.

I thought there was both some truth to Becky's charge and a revival of important features of her relationships with her parents. We explored some of the ways in which she and I had recently been drifting along into a jointly created sense of complacence regarding her external successes. As a result of this discussion, we focused more intensely on her current struggles, which included her blocked writing projects. She was reluctant to describe these in any detail, since they entailed technical material and controversies that she regarded as both arcane and tedious. She could not imagine I would be interested. But I was, partly because I am interested in the methodology of history and partly because I thought it might be an important route to understanding her current difficulties.

There ensued several months of on-and-off discussions of the topics of Becky's papers. Occasionally, I knew something about what she was struggling with and could offer some advice—rarely about the subject matter, but more about the process of writing itself. Most of the time, however, I just encouraged her to explain to me the issues and controversies—in effect, to teach me. She was hesitant at first, but as we went along, she was able to speak more freely; I was increasingly impressed by her brilliance and creativity, which I had not previously been able to glimpse firsthand. I found these sessions very lively, informative, and fun, sometimes almost exhilarating. Of course, with the guilt that is part of any psychoanalyst's repertoire, I worried that I was exploiting Becky for my own edification, and, of course, to some extent I was. But these discussions seemed important, and as we proceeded, she came more to life and her writing problems eased. It seemed important to me *not* to interpret what was going on between us at that point. I felt we had managed to cocreate a kind of experience that she had never had with

her parents, whose narcissistic concerns and investments made an enjoyment of Becky's own creativity either irrelevant or too threatening. After a while, the focus of our inquiry moved on to other topics.

Months later, Becky reported feeling better in many ways and no longer stalled in her work. Yet she still felt both pessimistic about ever feeling really likable, and also cynical about men. She knew how to get people to like her, she remarked, especially men. Because she had learned social graces from her parents, she could be quite charming, and because she was quite beautiful, she could dependably arouse men's sexual interest in her. But how would she ever feel that anyone really liked her for herself?

We had been over this ground several times before, including an exploration of her ambivalence about whether or not she wanted to believe that I found her sexually attractive. She wanted to believe that she had captivated me through her charms, because that made her feel special and valuable in a way with which she was familiar, but she simultaneously did *not* want to believe she had captivated me, because that would cheapen our relationship in a way with which she was also familiar. What I said at that point was something like this: "I think people, including men, sometimes like you very much for reasons over which you have absolutely no control." She reacted thoughtfully at the time to this interpretive statement, but did not bring it up again for six months, during which time her depression lifted further and her relationships with men became increasingly less tortured.

Looking back six months later, Becky noted how powerful my remark had been for her. It was an epiphany, perhaps the most impactful moment of our work together. What had happened? My statement might be regarded as an interpretation of Becky's conflictual ambivalence. Spelled out with all its implications, it conveyed something like this: You imagine you have omnipotent control over the impressions others have of you. This is partly an accurate appreciation of effective interpersonal strategies you developed as a child, and partly a fantasy you developed to ward off anxiety. But others have feelings about you outside your control, and if you could give

up your need to believe in your own omnipotence, you might find that interesting and satisfying.

But why did this remark, not so different from other interpretations made at many different points, matter so much at this precise juncture of the treatment? We will never know, but I imagine it was partly the result of what had been taking place between us in the previous months: as a byproduct of "getting down to business" by focusing on her writing projects, Becky had felt a heightened affective engagement between the two of us. She and I together had found a way to interact that granted much greater focus to her inner experience, both pain and creativity, than she had had access to before. Earlier, like both her parents, I had been somewhat absorbed in my own concerns and values, distracted from noticing the depth of her struggle with her writing. Later, unlike her mother, I felt sufficiently unthreatened to enjoy her talents and accomplishments; and unlike her father, I could share excitement and pleasure with her without leaving her feeling manipulated and controlled. Nevertheless, before the pivotal interpretation, Becky had drawn these new experiences into the old illusions of her omnipotent control over the excitement she aroused in others. With the interpretation made in response to the pessimism that emerged in her "no-search" self-reflections, it became clear to both of us that I was not delivering an abstract piece of understanding, but rather was expressing my own feelings about her that had developed through our focus on her blocked writing symptom.

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Ben[2] was a patient with whom I had worked for nine years with considerably constructive results; yet we returned again and again to his deep fear that I would be unable to help him with the depths of his depression. His childhood had been organized around his mother's debilitating depression, and he longed for me to save him from

[2] I have described my work with Ben from another point of view in Mitchell 2000, pp. 143-145.

despair more successfully than he had been able to save his mother from hers. Whatever positive developments we had been able to accomplish were episodically obliterated because he was still sometimes depressed; my analytic efforts had not purged him of that potential.

Six or seven years into the work, I found myself responding to stretches of intense attack on the meaningfulness of our work together with two exasperated outbursts.[3] At one point, I told Ben that if I were he and felt the way he did, as boxed in and trapped, I would be trying an antidepressant. At another point, I told him I felt we had come as far as we could go analytically. I believed, I told him, that he was continuing analysis because he longed for me to magically save him. And that longing, although very understandable in terms of his history, was perpetuating his suspension of meaningful living; it was trapping him, rather than facilitating a process that could help him any further. "No search" had become no life. He maintained his complex, partly passive-aggressive longing by repeatedly proclaiming that the analysis should "go deeper." "This is as deep as it gets," I said.

I think that the content of what I said at both points had some merit. Antidepressants are a complex option for many patients, and my interpretation of the magical feature of Ben's transference longings was something he and I had spoken about at various times before. But I brought up both issues at that point because I had reached the end of my rope, and that was pretty clear to him. Having my own effectiveness and the deeply meaningful value to me of our work episodically obliterated was beginning to get to me.

Ben was quite upset at these outbursts of mine, and we spent a long time processing them. One way he described his initial upset was to say that he felt as if he had been hit in the stomach with a shovel. We were both struck by the specificity of the image of the shovel; his association was to a spade. "Maybe I felt you were finally calling a spade a spade," he suggested.

[3] See Mitchell 1997, pp. 53-62, for a discussion of the utility of certain kinds of outbursts in analytic work.

I do not believe that I would have allowed myself to express my exasperation so openly with Ben had we not had a long history together, which gave me some confidence that we would be able to deal with it. In fact, we were. It subsequently became clear that there was something in my exasperation and sense that it was time to get down to business that suggested a limit to how much responsibility I was willing to bear for Ben's depression, the kind of limit he was never able to set with his mother in her claims on him.

In a session soon afterward, Ben explored the similarities between me and an interior decorator he and his wife had been consulting with enthusiasm. The decorator's company was called "Use What You Own," and it offered consultations on improving decor—at a cost short of the customary king's ransom—by rearranging the client's existing possessions. Ben and I kidded about my stance toward him in the analysis as a "Use-What-You-Own" approach. Previously, he had felt that I was offering only a dreary maturity, a hopeless renunciation, while he was holding out for a happy ending that would surely be his if he just stayed in analysis, "not searching," for long enough. Now he began to feel that the longings he had constructed in his childhood to keep hope alive in a truly dreadful and dreary world had become obstacles to experiencing a kind of robustness and vitality in what his present life offered.

With Ben, cultivating a "no-search" attitude was effective in helping him to tolerate his own depression and despair, and to suspend the strained, counterdepressive lifestyle he had constructed to ward off the terrors of his childhood. At other points in his analysis, it was effective to speak frankly about the ways in which his no-search stance threatened to keep him wandering in the analytic woods while he waited for a transcendent illumination, the promise of which kept him from appreciating the trees.

* * * * * * * * *

With each of these patients, there was a complex (generally not self-conscious) integration of the "no-search" approach and the

"let's-get-down-to business" approach. "No search" can lead to more creative, more personal experiences of love and work. Where it does not, something is wrong, and a more focused effort to deal with difficulties in living may be helpful, both directly and in its unintended byproducts. A "getting down to business," a focused exploration of difficulties in living, can remove obstacles to a more creative, more personal experience of love and work. Where it does not, it is often due to a kind of inner alienation from one's own experience—an internal self-sabotage, where less, rather than more, effort becomes helpful.

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Psychoanalytic Quarterly, LXX, 2001

"BUTTERFLIES CAUGHT IN THE NETWORK OF SIGNIFIERS": THE GOALS OF PSYCHOANALYSIS ACCORDING TO JACQUES LACAN

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> Once upon a time, I, Chuang-tse, dreamt I was a butterfly,
> fluttering hither and thither, to all intents and purposes
> a butterfly.
> I was conscious only of my happiness as a butterfly,
> unaware that I was Chuang.
> Soon I awaked, and there I was, veritably myself again.
> Now I do not know whether I was then a man dreaming I was
> a butterfly,
> or whether I am now a butterfly, dreaming I am a man.
>
> —Chuang-tse (c. 275 B.C.)

INTRODUCTION

In 1975, when Jacques Lacan stepped for the last time on American soil to lecture on psychoanalysis to the American public,[1] his reflections on the topic had matured during almost forty years of teaching and practice. Although changed in content and focus during his theoretical moves away from phenomenology to structuralism and beyond, his considerations of the "psychoanalytic cure" remained quite similar.

[1] For a French transcription of Lacan's 1975 talks at Yale University and at the Massachusetts Institute of Technology, see Lacan 1976.

In his seminars in the early 1950s, Lacan—evoking Freud—stressed the importance of analysis as furthering a "restitution" and "reintegration by the subject of his history right up to the furthermost perceptible limits," with the understanding that "history is not the past," but "is the past [only] in so far as it is historicised in the present" of analysis (Lacan 1988a, p. 12). However, he also underscored Freud's idea that analysis, while being concerned with both dimensions of thought and affect, should primarily focus on the analysand's ways of reconstructing and "rewriting" history through speech, rather than on an affective reliving of that very history in analysis.[2] Stressing the ways in which both thoughts and feelings are "inscribed" and signified through words and "noises of language" (grunts, sighs, coughs, mumblings—all elements of *lalangue*[3]), Lacan was only building on the Freudian idea that the unconscious is structured like a language, and needs to be interpreted as such.

From the very beginning of his teaching, Lacan wished to highlight that the dimension of speech in analysis was crucial not so much for its capacity to communicate and express, but rather for its power of revelation. This power of revelation alone provides access to the unconscious via an unforeseen, surprising deviation from the subject's consciously intended purpose of speech. "Revelation, and not

[2] The dichotomy between language and affect, or intellect and affect, seems to be set up at times by psychoanalysis itself, when we forget that Freud himself considered affects to be fundamentally displaced (the separation of *idea* and *quantum of affect* in repression), not providing in and of themselves testimony of any final truth. Lacan, despite the impression of some critics who accused him of explicitly excluding the dimension of affect from his work, devoted an entire year of his seminar (1962-1963) to a discussion of anxiety, which he conceptualized as the only affect that does not deceive, and which stands in a crucial relationship to the subject's desire.

[3] The term *lalangue,* in distinction to *langue* (language), was coined by Lacan to describe all those "parasites" of speech—stuttering, muttering, rumbling—that trace the remains of unconscious experience not properly signified. *Lalangue* also dwells in alliteration, assonance, and phonetic similes (such as "hole," "whole," and "all") that attract the analyst's attention and provide anchoring points for interpretation. *Lalangue* constitutes the woof of the unconscious and provides the foundation of the symbolic register.

expression," said Lacan, is the "other side of speech"; "the unconscious is not expressed, except by deformation, *Entstellung*, distortion, transportation . . . . Revelation is the ultimate source of what we are searching for in the analytic experience" (1988a, pp. 48-49).

This paradigm of revelation in speech that allows the subject of the unconscious to emerge, with its "truth" half said in slips of the tongue and other "parapraxes," reverberates throughout Lacan's seminars. In 1964, when reworking once more the Freudian unconscious and proposing the idea of the unconscious as "gap" or "abyss" (Freud's "navel of the dream" or *Kern unseres Wesens,* "core of our being") that splits, ruptures, and renders lacking the subject of consciousness, Lacan elucidated the paradox of the analytic revelation with the following story:

> In a dream, Chuang-tse sees himself as a butterfly. Upon awakening, he asks himself whether it is Chuang-tse who dreamt he was a butterfly, or whether it is not the butterfly who dreamt that he was Chuang-tse. "Indeed," wrote Lacan, "he is right, and doubly so, first because it proves he is not mad, he does not regard himself as absolutely identical with Chuang-tse and, secondly, because he does not fully understand how right he is. In fact, it is when he was the butterfly that he apprehended one of the roots of his identity—that he was, and is, in his essence, that butterfly who paints himself with his own colors—and it is because of this that, in the last resort, he is Chuang-tse." While the butterfly in the dream is a "butterfly for nobody," who is free not to tell anyone who he is, and hence to remain outside the dialectic of doubt versus certainty that plagues any ordinary, awake subject, Chuang-tse "will no doubt have to bear witness later that he represented himself as a butterfly," and is, therefore, captive in the network of signifiers. "It is when he is awake that he is Chuang-tse for others, and is caught in their butterfly net." [Quoted material from Lacan 1981, p. 76]

What does this little parable tell us about the subject's revelation in analysis? Several years later, Lacan answered that question (1975). Analysis, as he would put it then, is to bring about not only a reve-

lation, but an awakening, a brief instant of lucidity in which the subject, like Chuang-tse, wakes up to the structure of *his or her* world, and gets a glimpse of reality as a dream, with the dream revealing an imagined meaning bestowed on life by the dreamer.[4] During that moment of awakening, when the unconscious opens and closes up again on itself, as if driven by some need to "disappear" (Lacan 1981, p. 43), the subject, at the level of a "syncope of discourse," is joined for an instant with his or her desire (Lacan 1981, p. 26), just before reentering that "dream" which we all share and which we commonly call reality.

The elements of this story already provide a sense of the many paradoxes that Lacan's view of psychoanalytic treatment entails, and of the quite complex theoretical predicaments that underlie his formulations of the direction of treatment and of the ending of analysis. The present paper cannot be sufficiently detailed to do justice to those ever more complex theoretical formulations in their determination of the aims of analysis. Rather, we intend to evoke here some of the most distinctive features of a Lacanian understanding of the psychoanalytic process, in order to complete—as well as to contrast with—the other points of view presented in this collection of articles on the goals of clinical psychoanalysis.

In order to highlight those goals, we must briefly address the theory of the Lacanian subject, and articulate the function of the unconscious as it determines speech in analysis. This will lead us to distinguish between the subject's demand for a cure on the one

[4] In a rare commentary on Lacan's idea of awakening, J.-A. Miller (1991) stated:

> For Lacan, the question is, what would be a true awakening . . . . He thought that when you stop dreaming and you stop sleeping and open your eyes, it is to continue to dream with your eyes open. That is to say, reality is continuous with the fantasized world, and the effort of analysis is to bring about what would be a true awakening to the structure of *your* world, you as a subject—the true awakening to the signification, the meaning, with which your world is structured, and to the signification by which you live your life. [p. 98, italics in original]

hand, and his or her unconscious desire on the other, a desire that fuels the subject's attachment to the symptom, as well as his or her *jouissance* derived from suffering. *(Jouissance* is a term originally used by Freud [1896] to refer to the paradoxical—both pleasurable and painful—nature of sexual tension arising from the dialectic between the homeostasis and the "beyond" of the pleasure principle.[5])

Lacan actually differentiated three kinds of *jouissance:* (1) phallic *jouissance,* referring to *jouissance* inherent to the signifier in language, which both permits and limits sexual enjoyment; (2) the *jouissance* of the Other (also referred to as "feminine" *jouissance),* denoting the *jouissance* of the body, which is unspeakable, outside of the symbolic register; and (3) *jouis-sens,* which plays on the homophony of *sens* (meaning), referring to the *jouissance* of the unconscious and of the dream that incessantly creates codes, ciphers, and letters that limit and make significant the *jouissance* of the body.

All three forms of *jouissance* are excessive forms of enjoyment, going "beyond" the homeostasis of the pleasure principle. *Jouissance* represents the paradoxical relation between pleasure and the death drive. For example, according to Freud, the pleasure principle limits the *jouissance* of the unconscious in dreams. The limit on the excesses of *jouissance* is kept as long as we dream and continue to sleep without waking: "Dreams are the guardians of sleep," said Freud (1900, p. 233). If dreams are fraught with an excess of *jouissance,* the subject is awakened, as is often the case with nightmares. Depriva-

[5] Freud (1896), writing in French, explicitly referred to the "anticipated sexual enjoyment" *(jouissance sexuelle anticipée,* p. 58) for which the obsessive neurotic blames him- or herself. Implicitly, Freud seemed to be referring to an idea close to Lacan's concept of *jouissance* in his *Three Essays on the Theory of Sexuality* (1905), in which he elaborated on the paradoxical—both pleasurable and painful—nature of sexual tension within the pleasure principle. Freud seemed aware not only of the limits of his theory of homeostasis, but also of the fact that there was a "problem . . . how it can come about that an experience of pleasure can give rise to a need for greater pleasure" (p. 210). In a sense, Freud intuited the existence of a *jouissance* beyond the pleasure principle that is linked precisely to the subject's confrontation with and transgression of an inherent structural limitation in relation to sexual desire. (For an extensive discussion of this issue, see A. Patsalides 1997.)

tion of sleep, if excessive, puts life in jeopardy. *Jouissance* can thus potentially threaten life and extinguish desire. Therefore, all three —the pleasure principle, desire, and the signifier—both limit and permit *jouissance*.

The ways in which the analyst positions him- or herself in relation to the analysand's demand and his or her *jouissance* will be addressed in this paper in light of the analytic situation, the transference, interpretation, and—in particular—the analyst's desire. In principle, the analyst's desire corresponds to a "textual" desire, that is, a desire for the interpretation of a text forwarded through the analysand's free association. Interpretation in analysis is to bring forth a specific knowledge—analytic knowledge—about the subject's unconscious desire and his or her "fundamental fantasy." Interpretation is supposed to help the analysand move through the plane of identifications with ideals to a place of a "lack of being." This process follows what Lacan designated the "ethics of psychoanalysis," and potentially leads to a termination of analysis that does not correspond to achieving ideals of happiness or health, but instead to assuming the truly subjective position of not giving up on one's desire.

PSYCHOANALYTIC PRACTICE ACCORDING TO LACAN

As previously mentioned, Lacan's evolving positions on the objectives of analytic treatment are characterized by paradox. For example, to the question of whether analysis favors and should even aim for a certain experience of happiness, Lacan provided quite contradictory answers. While in 1960 (Lacan 1992) he decried the idea of the analyst making him- or herself "the guarantor of the possibility that a subject will in some way be able to find happiness even in analysis" as a form of "fraud," one fostering "psychological normalization" (p. 303) and eventually causing the death of desire, Lacan did not hesitate to state later on that ". . . they [neurotics] live a difficult life and we try to alleviate their discomfort . . . . An analysis

must not be pushed too far. When the analysand thinks that he is happy in life, that's enough" (1976, p. 15).

Although the latter statement might be considered the exception that proves the rule, it also reveals that Lacan, while elaborating a body of theory, was weary of being simply emulated by his followers, and made paradoxical statements lest his theory be turned into another ideal with which other analysts would identify. Most important, Lacan insisted that analysts should be suspicious in regard to their own desires to do good or to "cure"; he explicitly warned against the "benevolent fraud of wanting-to-do-one's-best-for-the-subject" (1992, p. 219). What Lacan put forward as the analyst's "non-desire to cure" (1992, p. 219) was resumed in his inaugural statement or "Act of Foundation" of 1967 (presented at the foundation of the École Freudienne in Paris), in which he specified the objectives of the psychoanalytic cure, as follows: "To restore to the symptoms their meaning, [and] to provide a place to the desires they mask" (Lacan 1991a).

One can hear this proposition reverberate with the double-entendre implicit in Lacan's formulation of the analytic task: to set free the enjoyment circumscribed by desire and meaning—*jouissance* and *jouis-sens*—which is entrapped in the symptom, congealing both the satisfaction the subject derives from suffering, and the suffering that he or she derives from satisfaction. In other words, the analyst is called on to liberate the *jouissance* encapsulated in the symptom (the passion caught in the symptom which amalgamates both pleasure and suffering) by deciphering the unconscious text that is "enjoyed," in condensation and displacement, through the symptom (*jouis-sens*).

Lacan clearly defined the cure as aiming at simultaneously freeing the subject's masked desire and restoring to the symptoms their meanings. Symptoms are not primarily to be seen as obstacles that need to be removed (their removal, in fact, is—as Freud agreed—only a byproduct of analysis). Rather, symptoms, in some ways similar to dreams, open the "royal road" to the unconscious. At times, Lacan was strongly attacked because his desire to cure analysands from their "illusions on the path of desire" (1976, p. 12) occasionally implied a purposeful heightening of the patient's anxiety in the session. In fact, Lacan believed that the anxiety that surges up "when

desire is sensed by the subject," emerging from a "confrontation with the image," opened up precisely the "fertile moment" in analysis in which a truly "mutative" interpretation could be made (1988a, p. 188). He had this to say about the timing of interpretation:

> That is when desire is sensed by the subject—which cannot happen without the conjunction of speech. And it is a moment of pure anxiety, and nothing but. Desire emerges in a confrontation with the image. Once this image which had been rendered incomplete is completed, once the imaginary facet which was non-integrated, suppressed, repressed, looms up, anxiety then makes its appearance. That is the fertile moment . . . . It is neither around, nor roundabout, neither before, nor after, but at the exact moment when what is close to bursting open in the imaginary is then also present in the verbal relation with the analyst, that the interpretation must be given so that its decisive value, its mutative function, can have an effect. [1988a, p. 188]

In order for the subject's disillusionment in regard to his or her imaginary identifications to occur, the experiences of anxiety (as the only affect that "doesn't lie") and of primary *Hilflosigkeit* (helplessness) are crucial, because they make palpable the actual experience of desire as a "particularly heightened tension," generated in a radical confrontation with absence and lack (of a satisfying object), both in the subject and in the Other. On the grounds of these formulations, Lacan was subsequently accused of lacking respect for his patients and their suffering. Feeling misunderstood, he responded that "our justification, as well as our desire, is to ameliorate the position of the subject" (Lacan, unpublished).

To achieve this amelioration, the analysis has to bring the subject to recognize the ways in which (or, more precisely, the signifiers by which) he or she is being determined by the Other's desire, so that the subject, in a second move, can assume, together with his or her own alienation, the reality of his or her own desire. This process corresponds most closely to the gist of Lacan's manifold readings of Freud's "*Wo Es war, soll Ich werden*": "There where it was" (the subject as "it," as object of the Other's desire, the subject in the place of the

object caused by the Other's desire)—"it is my duty that I should come to being" (it is my responsibility to emerge into being as my own cause).[6]

The question now raised is: "What is this *I?"* To provide an answer, we will have to turn to the notion of the *subject,* as elaborated by Lacan.

THE LACANIAN SUBJECT

We are the hollow men
We are the stuffed men
Leaning together
Headpiece filled with straw. Alas!
—T. S. Eliot (1925)

Lacan's view of the subject implies several important distinctions that decisively impact the conduct of analytic treatment. The Lacanian subject cannot be understood without an introduction to the three registers of the Imaginary, the Symbolic, and the Real, which provide its coordinates. Lacan presented his first elaboration of the three registers in their application to the psychoanalytic cure on July 8, 1953, in a conference at the Société Française de Psychanalyse (see Lacan 1982).

To the Imaginary belongs what we know as the ego. The ego is a formation completed at the end of the mirror stage (at about six to eighteen months of age), which condenses the child's fragmentary sensations of the body and the image as perceived in the mirror into a unified self-image. The ego, therefore, equals an illusion of cohesion, wholeness, and identity that entails the alienation of recognizing "me" as "other," outside of "me."

[6] Freud's *Wo Es war, soll Ich werden* was extensively commented on by Lacan. For more on its translation to "There where it was, it is my duty that I should come to being," see Lacan 1977, p. 129.

The Symbolic produces the subject proper, which is the subject of the unconscious. The Symbolic, as the unconscious, is structured like a language and represents, therefore, a conventional, discontinuous, and arbitrary system. The Symbolic is regulated by differences in which elements take on value and positive existence only insofar as they relate to and are distinct from other elements in the structure. The Symbolic is governed by what Freud formulated as primary processes (condensation and displacement); Lacan, following the linguist Roman Jakobson, reformulated these processes as metaphor (condensation) and metonymy (displacement). The subject is determined by the laws ruling the symbolic order; it is an effect of signifiers and is conceived in speech (by the parents) before being born as a subject who begins to speak.

The Real, distinct from the Symbolic and the Imaginary, does not know the distinction of oppositions, of presence and absence: it is undifferentiated within itself. The Real concerns the subject insofar as it produces repetition, and is that which always returns back to the same place, as in repetition compulsion. The Real, *qua* "impossible," resists signification in the symbolic register; it is seen as the essential element in trauma, in that trauma insists on repetition of that which is "unassimilable" to the subject (Lacan 1981, p. 55). Trauma confronts the subject in an ever-missed encounter with this "real" object of anxiety that cannot be named.

Lacan's subject essentially follows Freud's own theory of *Ichspaltung* (splitting of the "I"), delineating a subject that is divided or split into two agencies: the subject of consciousness (the imaginary construct of the ego), and the subject of the unconscious, barred by and alienated in language (in Lacan's denotation, this barred subject is designated by the symbol "$"). On both the imaginary and symbolic levels, the subject encounters a gap that induces alienation, which occurs through the experience of an unbridgeable difference between the image in the mirror and the "I" ("Look, baby, that's you!"), and alienation in the subject's forced choice to express his or her *self* with signifiers stemming from the Other—signifiers that precede his or her birth and determine his or her place in the Other's desire, with which the subject needs to come to terms.

Lacan's favorite paradigm illustrating the insertion of the subject into the language of the Other exemplifies one of his many "returns" to the work of Freud. To Freud, the by now famous example of the *Fort/Da*—a little boy throwing and retrieving a wooden reel on a string while babbling "o-o-o-o" when it was gone and *"da"* when it was again present—demonstrated the child's mastery of mother's absence through a process of signifying substitution. The child, by throwing and retrieving the reel, symbolizes the possession of active control over mother's comings and goings, thus illustrating a symbolic mastery over the lost object, the mother. Lacan, however, went beyond Freud's thinking in his insistence that the child's access to language is central to *fort/da*, because it determines the essentially split or barred status of the subject in the unconscious. By nominating presence *("da!")* and absence ("o-o-o-o") with preexisting signifiers that are first provided by the environment (the Other), and not by the subject, the child may well master the experience of being deprived of an object; however, by inserting him- or herself into the binary structure of these phonemes ("o/a"), the child becomes subjected to what Lacan called the law of the *symbolic order*. The split in the subject between mastery and subjection points, in Lacan's view, refers to the fact that the accession to language and symbolization, while instituting the birth of the human subject, at the same time implies the death or "murder" of the object, because the thing needs to be gone ("o-o-o-o") for the symbol *("da!")* to be there.[7]

How can we understand that the subject is produced as an "effect of signifiers" originating in the Other? To answer this question, we need to accept two assumptions about the human subject, as follows:

(1) That as humans, we are born into the symbolic structure of language (the "Other"), which precedes and determines our own speech, our production of signifiers. (A signifier is the phonological element of the linguis-

[7] For a detailed Lacanian reading of *Fort/Da,* see B. Patsalides 1997.

tic sign, the acoustic image that stands in an arbitrary relationship with the signified, which represents the conceptual element of the sign. For example, the association between the acoustic image or signifier *w-a-t-e-r,* and the mental concept corresponding to the transparent liquid, is completely arbitrary and conventional. Each language has different signifiers—such as *water, eau, Wasser, agua*—for the same signified.)

(2) That our unconscious is constituted by the effects of the signifier on the subject, in that the signifier is what is repressed and returns in unconscious formations, such as jokes, dreams, and symptoms. Freud's famous example of "Signorelli" (1901) explains such repression and substitution of signifiers in the psychopathology of everyday life, beautifully illustrating the split nature of the speaking subject.

In contradistinction to some schools of analysis that might endeavor, through the workings of the cure, to heal this split, to end alienation, and to bring about at the end of analysis a subject who would be "one" or unified with him- or herself, the Lacanian subject, even when analyzed, remains forever divided, since this division is the condition of the speaking being per se.

Produced thus as an effect of signifiers that originate in the Other, the subject is marked by a double lack. The first lack concerns the fact that the signifier can never recapture the originally "lost" object of an original need satisfaction that produced pleasure; this loss implies that the subject alternately appears and disappears in a continuous movement from signifier to signifier, but can never identify with any one—the main characteristic of the "subject of the unconscious is that of being . . . at an indeterminate place" (Lacan 1981, p. 208).

In regard to this first lack, related to the object cause of desire and the object of the drive, Lacan (1981) gave the following example:

> Take the experience [Freud's example] of the beautiful butcher's wife: She loves caviar, but she doesn't want any.

> That's why she desires it. You see, the object of desire is the cause of desire, and this object that is the cause of desire is the object of the drive—that is to say, the object around which the drive turns . . . . It is not that desire clings to the object of the drive—desire moves around it, in so far as it is agitated in the drive. But all desire is not necessarily agitated in the drive. There are empty desires or mad desires that are based on nothing more than the fact that the thing in question has been forbidden you. By virtue of the very fact that it has been forbidden you, you cannot do otherwise . . . than think about it. [p. 243]

The second lack in the subject is anterior to the first, and refers to the fact that, by entering life and the fields of sexual difference, the subject becomes submitted to the reality of death. The loss of this "something" at birth (to Lacan, a loss of libido) essentially comes to constitute the object–cause of desire (object *a*), around which the drive revolves, and which constitutes the kernel of the real in the symptom—that which repeats itself and does not make sense—and which provides us with the formerly described, enigmatic, and irreducible *jouissance*.

As a consequence of the two forms of lack, the subject undergoes a twofold alienation: alienation and "loss of being" produced by the identification with the signifiers of the Other, and alienation through the impossibility of acceding to *being*, to embodying the object of the Other's desire. The realization of this impossibility implies the recognition that the Other is also lacking. The following vignette will shed some light on these dynamics.

CASE VIGNETTE: LEE

Lee, a 15-year-old, comes to treatment at her parents' suggestion, complaining of feeling cold, empty, and bored, "not looking forward to anything." Lee is plagued by recurrent, severe back pain, and lags behind in her sexual development (notably, she has not begun to menstruate). Her parents accuse her of falling behind at school because she cuts classes. Lee hates her father for constantly pressur-

ing her with such commands as: "You must never see anyone's back in front of you—always be first!"

Lee comments to her analyst, "My father is such a pain in the back!" The ideas of being *in front* and of never seeing anyone's *back* represent Lee's master signifiers (word representations governing her life), which fixate her into a distressing symptomatology and an alienating, physically androgynous body image. She associates to her father's directive to "never see anyone's back in front of you," her own lack of any "*backing*" or "*back*drop" in the depths of her isolation, and links the injunction to look "forward," in "front" of her, with a prohibition to look *backward*, into the past.

Whenever Lee asks her parents about the details of her birth, she is met with an awkward silence followed by a quick change of subject. The course of analysis uncovers, through an acting out on her mother's part, that Lee was conceived by artificial insemination —a secret kept from her by both parents. As analysis revealed, Lee had unknowingly "embodied" the forbidden knowledge of the past (her conception) in her *back* pain, as well as in her androgynous identification, which kept her fixated to the signifier of the *back,* which in turn concealed sexual difference. Lee discovered that her ambiguous given name in fact inscribed her father's desire for her to be "first in line" and sexually undifferentiated, which meant that she should be deprived of a place in the continuity of a lineage or cycle of reproduction. The existence and identity of her biological, genetic father had to be eradicated from memory, but returned as a "signifier" (representation) inscribed in her body. The associative network around *back* structured her symptoms. Following the discovery of new links in the signifying chain (*father, behind the back, back pain, pain in the back, looking backward, staying/lagging behind, the past),* Lee began to menstruate.

The case of Lee illustrates several points about the Lacanian subject. As Lacan repeatedly stressed:

> Symbols in fact envelop the life of man in a network so total that they join together, before he comes into the world, those who are going to engender him "by flesh and blood"; so total that they bring to his birth, along with the gifts of

> the stars, if not with the gifts of the fairies, the shape of his destiny; so total that they give the words that will make him faithful or renegade, the law of the acts that will follow him right to the very place where he is not yet and even beyond his death. [1977, p. 68]

Once Lee recognized the function of the signifiers *back* and *front* in the economy of her father's (and mother's) desire, and assumed her unconscious knowledge about the blank scene within which she had been conceived, she was able to "arrive" into being the cause of her own desire and to start her menstruation. Her body seemed to have responded to the analytic process with a sign. And a sign could be noted by the analyst as the precursor of the signifier, a "something intended for someone," as yet to be formulated in speech.[8]

TRANSFERENCE AND THE END OF ANALYSIS

Transference in Lacanian analysis is related to the concept of the *subject supposed to know*. When the analysand comes to treatment with a demand for relief, improvement, resolution, or even "cure" of an ill, he or she implicitly infers that the analyst knows something about the cause of his or her suffering. This transfer of a "knowing more about the cause of suffering" to the analyst turns the latter into a "subject supposed to know" (or "supposed subject of knowledge"), placed in the locus of an "Other" knowledge: the unconscious. The

[8] As an example of a sign—in contradistinction to a signifier—Lacan mentioned Anna O.'s nervous pregnancy (Freud 1895). "What did she show by this?" asked Lacan.

> Let us say simply that the domain of sexuality shows a natural functioning of signs. At this level, they are not signifiers, for the nervous pregnancy is a symptom, and according to the definition of the sign, something intended for someone. The signifier, being something quite different, represents a subject for another signifier. [Lacan 1981, p. 157]

analyst, destined to be a subject through his or her own analysis, knows, however, that the "Other" knowledge to which the analysand appeals is possessed neither by the analyst nor by the analysand; the analyst knows that the subject supposed to know is not him- or herself, but that it is the unconscious. In fact, with respect to that "Other" knowledge, analyst and analysand can be said to be equally ignorant.

> Here we have this man, the psychoanalyst, from whom one comes to get/look for the knowledge of what one has as the most intimate—that's most commonly the state of mind with which one would approach him—and hence of that which one could by definition suppose to be for him the most foreign. And yet, at the same time, it's that which we encounter at the beginning of analysis—this knowledge, he is supposed to have it. [Lacan 1991b, p. 81]

Nevertheless, despite the *ignorantia docta*—learned ignorance—with which he or she is endowed, the analyst knows that through his or her direction or handling of the treatment, unknown knowledge will emerge as a byproduct of intersubjectivity, instituted by the four terms or "players" who interact in the analytic "field": the ego of the analysand, the alter ego or ideal ego as projected onto the analyst, the subject of the unconscious, and the Other as locus of the unconscious structured like a language. (These four terms are also to be found in Lacan's schema *L,* as first elaborated in Lacan 1988b; see also Lacan 1977, p. 139.)

It is in this field of four players that the analyst elicits the subject's associations, which, by and by, will reveal which Other the subject is truly addressing in the transference.

> The analysis consists in getting [the analysand] to become conscious of his relations, not with the ego of the analyst, but with all these Others who are his true interlocutors, whom he hasn't recognized. It is a matter of the subject progressively discovering which Other he is truly addressing, without knowing it, and of him progressively assuming the relations of transference at the place where

> he is, and where at first he didn't know he was. [Lacan 1988b, p. 246]

Transference in this sense, as Freud had already recognized, is a "deception" or "false connection," involving true knowledge being displaced from one situation (infancy/childhood) to another (analysis) by false attribution. Because transference both misleads and deceives by presenting truth in the form of lies, transference could truly be called the "enactment of the reality of the unconscious" (Lacan 1981, p. 146). The subject speaks the truth in negation or when the tongue slips, as in "This woman in the dream is for sure not my mother, but I wanted to *kill*—no, sorry, to *call*—her on the phone."

Whether the analyst is placed by the analysand in the position of the ideal ego (imaginary Other), and therefore supposed to provide narcissistic gratification (admiration, love, hate); or in the position of the ego ideal (symbolic Other), who is expected to impart a (positive or negative) judgment; or in the position of the Real Other, solicited to embody the object *a* (cause of desire) and to provide *jouissance,* the analyst will always have to respond not by an interpretation of the *fact* of the transference ("You are taking me for your mother"), but by analyzing that which is transferred or projected *from within* the transference.[9] The difference here lies in the fact that in the former case, transference is interpreted in terms of a false connection that repeats some past relationship, whereas the latter implies transference as an act of interpretation on behalf of the analysand, which involves the subject in the search for the why and wherefore of this false connection.

Before 1964, the aim of psychoanalysis was to analyze the transference in order to make conscious and modify the subject's symbolic relations, and to correct his or her position vis-à-vis the Other (the law, the social order, and so on). Analysis was directed at resolving fixations in imaginary and symbolic relations (especially if they

[9] In Lacan's words: "As an analysis develops, the analyst deals in turn with all the articulations of the subject's demand. But . . . he must respond to them only from the position of the transference" (1977, p. 256).

were detrimental to the realization of the subject's own desire—such as, for example, intense rivalry, or the fear of succeeding or of being judged). After 1964, the position of the analyst as Real Other, cause of the analysand's desire (object *a),* was considered crucial for a possible end to the analysis in which the subject's "destitution" could be realized. The term *destitution* rightly indicates that the end of analysis, in Lacan's view, has to do with a certain impoverishment, a recognition of loss and of lack, a renunciation of ideals.

In order for the transference to shift so that the analyst is positioned as the Real Other, an important, if not final, step has to be accomplished in the analytic process: the crossing or traversing of what Lacan defined as the fundamental fantasy. The notion of fundamental fantasy is crucial in Lacan's work. It denotes the specific structure of the fundamental relationship between the divided subject (barred by language, "*$*") and the Other's desire as cause (written by Lacan as the following formula: "*$* [diamond] *a").* For example, the second phase in Freud's well-known analysis of infantile beating fantasies ("A Child is Being Beaten" [1919])—namely, the reconstructed fantasy of "I am being beaten by my father"—conveys the relation between the subject and the Other's imputed desire to punish. The fantasy here is not necessarily a mere image; it always involves an "image set to work in a signifying structure" (Lacan 1977, p. 272). The fundamental fantasy serves the function, among others, of defending against the recognition of castration and of the lack of the Other; it also stages the subject's particular mode of *jouissance,* and is thus closely related to the symptom. Each clinical structure (neurosis, psychosis, perversion, any one of various psychosomatic phenomena) is characterized by a specific structure of the fundamental fantasy, a specific way in which the subject positions him- or herself in response to the question, "What does the Other want from me?"

Crossing the fundamental fantasy involves recognizing the nature of both one's preferred object of desire, and one's preferred way of positioning oneself as the object of the Other's desire (hence, the subject's active and passive positions in the fantasy). It implies traversing the "plane of identification" (Lacan 1977, p. 273), which refers to a change of place in the structure of discourse, rather than

to changing a specific behavior. When the analysand crosses the plane of identification, he or she recognizes the illusion in wanting to gain gratification from identifying with a meaningful trait that the analysand could adopt from the analyst. In contrast, that very object previously coveted by a desire for identification is now discovered to be the object *a*, an object forever lost.

Crossing the fundamental fantasy also implies a change in the *analyst's* position: from standing in the place of the desired object, the analyst comes to occupy the place of the object that causes desire. As long as the analyst is considered or acts as if he or she were the object of the analysand's desire, transference can only bring about a repetition of past events, relationships, and acts, and the end of analysis can only occur as a process of identification. If the analyst holds the place of the object that *causes* desire—a place that Lacan compared with the figure of the dummy in a game of bridge, or the one who "makes death present" (Lacan 1977, p. 140)—then the analysand becomes detached from both ideals and the object. This is precisely the point at which the analyst can respond to the analysand's love with knowledge about love that the analyst obtains through giving an empty space, "nothing": "Love is to give what you don't have" (Lacan 1977, p. 255). To the seduction and lures of the transference and the analysand's love (which is always imaginary), the analyst has to respond with an Other desire. This Other desire, or desire of the analyst, is

> . . . not a pure desire. It is a desire to obtain absolute difference, a desire which intervenes when, confronted with the primary signified, the subject is, for the first time, in a position to subject himself to it. There only may the signification of limitless love emerge, because it is outside the limits of the law, here alone it may live. [Lacan 1981, p. 276]

The desire of the analyst "to obtain absolute difference" could be interpreted on many levels: as a difference in the analyst's position, between that of *object* of desire and object *cause* of desire; or as a difference between the analysand's demand (for an object of satisfaction) and the analysand's desire (circulating only as a function of

the lack of an object of satisfaction); or as a difference in the sense of "alterity" that pertains, as one commentator put it, to what Freud called *anaclitic love,* or love of the unknown and radically different, which is opposed to narcissistic love.[10]

From the place of the object *a,* the analyst induces an experience of lack (of the object) in the subject, which in turn elicits the subject's speech. This is what is meant by the analyst's *direction* of the treatment. Only if the analyst occupies the place of the object that *causes* desire (the object *a*) can the analysis abandon the aim of any ideals, inducing—through the process of separation—a detachment from the object. We could interpret this process as Lacan's version of "liquidation of the transference": the transference, said Lacan, "isolates the [object] *a*, places it at the greatest possible distance from the *I* that he, the analyst, is called upon by the subject to embody. It is from this idealization that the analyst has to fall in order to be the support of the separating [object] *a*" (1981, p. 273).

We will come to see in what follows how the analyst, knowing nothing, may respond from the place of the object *a* with interpretation.

INTERPRETATION, OR: KNOWLEDGE IN A PLACE OF TRUTH

Interpretation, to both Freud and Lacan, is the cornerstone of analytic practice. Freud regretfully stated that "It's a pity that one cannot make a living . . . on dream interpretation" (1985, p. 26)! Lacan defined interpretation as "knowledge in place of truth," which, as such, must define the structure of interpretation (1991c, p. 39). In formulating a model reflecting this statement, Lacan defined interpretation as situated between an "enigma" and a "quote" (1991c, pp. 39-41). An enigma is a saying that belongs to no one and does not correspond to any statement of knowledge. For Oedipus, the question of the Sphinx was the enigma that required an

[10] See Dunand 1995.

answer from him. To the analysand, a question such as "What am I doing with my life?" may constitute the enigma.

A quote, in contrast, is a statement of knowledge, referring to an author and conveying the author's latent desire ("It's a pity that one cannot make a living on dream interpretation," for example). Interpretation, therefore, stands in between the enigma that conveys a truth with latent knowledge, and the quote that states a knowledge with latent desire. Interpretation is stated in the form of an allusion, a "half-saying" that avoids the formula of "this is/means that."

Analytic treatment is based on the premise that speech is the only means of revealing the truth about desire. In analogy to the fact that truth about desire is most often revealed in failures of speech (parapraxes), interpretation is aimed not at the consciously intended object or meaning of the analysand's speech, but at the object *a* cause of desire, "driving" his or her speech. In order to unveil the cause of desire—an impossible goal—analytic interpretation must avoid becoming itself an object that corresponds in any way to the analysand's expectation and demand for understanding or for being understood. "Analytical interpretation is not meant to be understood, it is meant to provoke waves," stated Lacan (1976, p. 35). "Understanding" is anathema to the Lacanian analyst: it either betrays the fact that we as analysts are not sufficiently curious, or that we fool ourselves by indulging in some illusion of imaginary mastery over meaning.

Without any doubt, the purpose of interpretation is by no means merely to unveil hidden meanings, or to augment in any other way the analysand's imaginary knowledge about him- or herself. In this context, we should differentiate between imaginary knowledge held by the ego *(connaissance)* and symbolic knowledge held by the subject *(savoir)*. Imaginary knowledge, meaning the ego's illusory self-knowledge based on a fantasy of unity and self-mastery, usually obstructs the way to symbolic knowledge, which is the "unknown knowledge" of the unconscious, characterized by a gap between the subject and knowledge. Analysis makes symbolic knowledge emerge as an intersubjective fact: located in the defiles of the signifier, it belongs neither to the analyst nor to the analy-

sand. It is revealed, as previously stated, during those short moments of awakening that interpretation sometimes produces.

The very success of an interpretation is to be measured by an "effect of truth," relative to the extent to which it affects the analysand's subjective position (that is, stirs up memories of thus far repressed traumatic encounters, and changes the subject's relation to desire). This effect of truth, which is conveyed through particular formations of the unconscious (dreams, slips of the tongue, symptoms), emerges through a new combination of signifiers in the analysand's associations, which the analyst may allude to in his or her interpretations.

Toward the aim of giving access to the truth of the subject's desire, the analyst must take the subject's speech absolutely literally, and interpret the very statements that are ambiguous and equivocal in their phonemic, grammatical, or logical structure. Homophony (that is, phonemic equivalence) manifests in words having identical sounds yet different meanings. To a patient complaining that "I am lazier, uglier, fatter than everyone; I don't belong to the human race," the analyst might reply, "But you might *win* the race." A patient who makes a slip in grammar by saying "I am writing this ten years ago" reveals that what he or she wrote ten years ago is true now and applies to the present moment.

A logical ambiguity is expressed in the following example: A patient struggling in his relationship with his girlfriend states, "I don't know what to do with Anna." The analyst's response puns: "You can take her from whatever side, it's always Anna."

The following vignette offers another example of such an ambiguous interpretation.

> Ms. C complained of feeling that she was not worthwhile, was unable to make herself heard among her friends and family, did not have a place in life, and most of all, was unable to earn a living. In a dream reported in her session, she was standing in a church-like building. Someone handed her a vessel resembling those from Roman times, filled with something precious. Another figure then took the vessel from her hands, stating that she had received it

by mistake, as she had not yet fulfilled the necessary rites. This vessel, Ms. C associated, had the shape of an ancient urn made of clay, resembling those found at burial sites.

At that moment, the analyst intervened: "You were handed an *urn* that you didn't *earn?*"—stressing in her voice the homophony of those signifiers.

Quite abruptly, Ms. C rose in her chair, as if shaken by sudden fright, and started to cry.

Further analysis of this patient revealed that the signifier *urn* in the dream not only evoked a long-forgotten memory of her beloved grandmother's unburied ashes, which were stored in an urn in her parents' house, but had also established a sudden new connection between two homophonic signifiers *(urn* and *earn),* whose signifieds Ms. C had never considered in relation with each other. This new knowledge, deciphered from the text of her dream associations, provoked a turning point in her treatment. Ms. C began to realize to what extent she had identified with her deceased grandmother, who, like Ms. C herself, had had repeated psychotic episodes, and had been refused a burial because of the family's shame in regard to her mental illness. Ms. C subsequently elaborated that her incapacity to earn money and assume a place in the social structure represented a rebellion against her family's unwillingness to inscribe the grandmother into the symbolic structure of filiation (by refusing to have her ashes buried and marked with an inscription on a gravestone). Ms. C also acknowledged that her repetition in symptomatology (insisting on the signifier *[not] earning,* in connection with signifieds such as *money, respect,* and *value),* represented a failed attempt to mourn and symbolically signify her grandmother's death.

Besides punning on the ambiguity of signifiers, there is another way of disrupting (conscious) meaning in speech: the interpretation by punctuation, that is, by cutting short an analytic session. Lacan's idea of utilizing time—the variable length of the session—as a means of interpretation was based on his theoretical distinction between logical and chronological time. Lacan (1988c; see also

Samuels 1990) proposed that the time operative in the unconscious is logical, not chronological, and that therefore, chronologically timed, 50-minute psychoanalytic sessions are not adaptable to the logic of the unconscious. (Although this distinction between logical and chronological time is important for the practice of analysis, the utilization of short sessions has been mishandled and possibly abused by some Lacanian analysts, to the discredit of Lacanian analytic practice.)

According to Lacan, the time of the unconscious, logical time, can be divided into three elements: (1) the instant of the gaze or look; (2) the time of understanding; and (3) the moment of concluding. This differentiation into three elements is based on modern game theory and the paradigm of "the prisoners' dilemma." Briefly, this paradigm can be explained as follows:

> Of three prisoners in jail, one is to be set free by the authorities. The authorities invent a logical game, the winner of which will be the one liberated. Each is made to wear on his back either a white or a black disk (out of a total of three white and two black disks), and each is unable to see the color of the disk he himself wears, but can see the other two prisoners' disks. Communication is forbidden between the three, and there are no mirrors. The first prisoner who determines the color of his own disk must exit through the door, declare his color, and provide a logical explanation for his guess; if he is right, he will be released. The prison director chooses white disks for all three prisoners, and the game begins.
>
> The first logical "time"—the *instant of the look*—consists of each prisoner's seeing two white disks on his fellow inmates' backs, and immediately excluding one of the three possible combinations (namely, that of one white and two black disks). While each prisoner makes the same logical exclusion, the problem is still unsolved and all three need more *time to understand* (the second logical "time"). In the first instant of seeing, initial evidence is given that has two elements: what the subject sees (the two white disks), and what the subject does not see (any black disk). What the subject does not see entails an "original interdiction" (La-

can 1988c, p. 9), namely, the combination of three black disks.

Lacan showed that the subject (prisoner) in this first instant of seeing is a Real subject, a subject in the Real that ignores his own attribute and is only confronted with the Real of a perception to which it cannot yet attach a signifier (or for that matter, any meaning). During the second logical time, the time of understanding, each prisoner observes the behavior of the others, trying to figure out the color of his own disk. There are two choices left: either I am black (in which case, the two whites that I see would each see one white and one black, and hence conclude that if they were black, the other white one would have already recognized himself as being white and rushed to the door), or I am white (in which case we are all white and we should all rush to the door).

Lacan stressed that an imaginary process is involved during the "time of understanding," with each subject thinking about what the other two must think and see, in a completely reciprocal manner. During the time of understanding, the subject is caught in the imaginary reciprocity or "subjective transitivism" (imagining and anticipating what the others are seeing and thinking), which also implies the suspension of action. This suspension of action will be interrupted at the moment when one of the three prisoners, seeing that neither of the others are leaving, will *conclude* that he is white and rush toward the door. Lacan pointed out that the subject, having understood, has to then rush to transform this understanding into an *act of conclusion* (the "third logical time"), in order to win out over the other two subjects, who may arrive at the same understanding at the same time. Lacan added that if the "action is delayed by one instant, by the same token he knows that he will be thrown into error" (1988b, p. 289), for he will fall back into the ambiguity and uncertainty of the moment before.

> It is a sophism, as you are well aware . . . . Everything hangs on something ungraspable. The subject holds in his hands the very articulation by which the truth he sifts out is inseparable from

> the very action which attests to it. [Lacan 1988b, pp. 288-289]

Lacan underlined that in order to be freed from the imaginary fixation with the other two prisoners, the subject must be motivated by anxiety and a certain urgency. It is the fear of the Other that pushes the subject to assume the certainty of a subjective judgment, which in turn propels him to leave the relative comfort of the imaginary, narcissistic identity and accede to the symbolic order.

While in the story of the three prisoners, the subject stops with the "I" of identification (I am white), the experienced analyst knows that analysis needs to go beyond that point. In additional commentary to his "Seminar on the Purloined Letter," Lacan (1966, p. 49) introduced the object *a* as a fourth logical moment into the threefold structure of instant of the gaze, time of understanding, and moment of conclusion. Here, Lacan equated the position of the analyst with the excluded/included object (a), or black disk, and therewith focused the end of analysis on an interpretation of the presence and desire of the analyst. For it is this presence which is contained in, and yet exceeds, the Real, the Imaginary, and the Symbolic.

> The question of the end of analysis then becomes the question of how one can exit from the prison of language. Lacan's solution to this problem is centered on his logic of exclusion and his theory of separation. For it is the door of the Other that the subject must cross in order to become the object of analysis. [Samuels 1990, pp. 69-77]

As illustrated in the paradigm of the three prisoners, these three elements of time correspond to three different modes of the subject's "subjectivation," in the orders of the Real, the Imaginary, and the Symbolic.

Although Lacan insisted that the dialectic oscillation between the three can never be dissolved, he developed the idea that a fourth logical time could be introduced in an analytic treatment through the above-mentioned interpretation aiming at the object *a*.

To interpret while aiming at object *a* requires that the analyst must forget what he or she knows while listening, and encourage *non-sense* to be produced, in which the subject, beyond meaning, should see "to what signifier—to what irreducible, traumatic, non-meaning—he is, as a subject, subjected" (Lacan 1981, p. 251). In stating that the analyst's ego had to erase itself in favor of obtaining a "subject-point" of interpretation, Lacan meant that

> . . . the analyst had to strip his narcissistic image of the ego of all forms of desire that led to its constitution, so as to reduce it to the sole figure that sustains it behind the masks of its desires, namely that of the absolute master, death. [Lacan 1966, p. 348, translated by B. Patsalides and A. Patsalides]

The analyst's "being for death," which took the place of his or her ego, was further elaborated into the notion of living "in-between two deaths," which referred to the zone between the symbolic death effected by the signifier, and the real death of all mortal beings. Leading up to his seminar on the ethics of psychoanalysis, Lacan had already stated in 1955:

> And this would be the required end for the analyst's ego, of which one could say that it must only know the reputation of a single master: death—so that life which he must lead through so many destinies, be his friend. [1966, pp. 348-349, translated by B. Patsalides and A. Patsalides]

"HAVE YOU ACTED IN CONFORMITY WITH YOUR DESIRE?" THE ETHICS OF PSYCHOANALYSIS

The question of ethics in psychoanalysis is foremost related to the problem of guilt, as elaborated by Freud in regard to masochism and the agency of the superego. Freud formulated the conflict between essentially amoral sexual drives and the demands of civilized morality. To Lacan, the issue of guilt is framed in a radically different

way: "From an analytic point of view, the only thing of which one can be guilty is of having given ground relative to one's desire" (1992, p. 319).

In directing treatment, the analyst thus follows an "ethic of desire," which is opposed to the traditional ethic of the "good" as described by Aristotle, Kant, and other moral philosophers. The psychoanalytic ethic considers the good and the analyst's wish to "cure," for the benefit and well-being of the analysand, as an obstacle to desire; hence, a "radical repudiation of a certain ideal of the good is necessary" (Lacan 1992, p. 230), which explains on a different level why analysis may call into question all ideals of health and happiness.

As traditional ethics tend to correlate the notion of the good with pleasure, and as analysis has recognized the duplicity of pleasure (in the sense that, when transgressed at its limit, it turns into pain), many analysts reject the idea that treatment should necessarily lead the subject to greater pleasure. On the contrary, by concentrating his or her attention on the analysand's *jouissance,* the analyst inadvertently confronts the analysand with the issue of death, inherent to desire and *jouissance.* Recognizing the question of whether one has acted in accordance with one's desire leads the subject unavoidably to the experience of the absolute, Freudian *Hilflosigkeit* beyond anxiety; and this is necessary, as previously stated, to the actual experience of desire. It is this *Hilflosigkeit,* insofar as it opens the way to an "impossible" desire, to which the subject in analysis needs to be given access. The subject, however, is not to remain at the level of *Hilflosigkeit;* he or she is to take on the responsibility of—the ability to respond to—whatever his or her desire calls for.

The ethics of desire does not imply that the subject could or should do whatever he or she pleases; rather, desire always calls for an interpretation. In contrast to the ethics of the good, which request of the subject that as much as possible be done (and that it be done as well as possible), the ethics of desire, as applied in analytic practice, request from the subject that something be done that is beyond what is possible, at the perimeter of the impossible. This request stands in response to the analyst's arduous endeavor of

Analysieren, which, as Freud proclaimed in "Analysis Terminable and Interminable" (1937), is an "impossible profession" (p. 248).

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Psychoanalytic Quarterly, LXX, 2001

THE PATIENT'S EXPERIENCE OF THERAPEUTIC BENEFIT

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Not too long ago, I ran into a friend of mine at a party. The successful CEO of a large company, he is extremely skeptical about psychotherapy; so it was with a kind of grudging amusement that he said he had a story to tell me that he thought I would enjoy hearing. He had just had the pleasure of hiring for a very well-paid position a man named Ralph, whom he had known fairly well at one time, but had not seen for ten years. My friend was astonished at how Ralph had changed. Ten years ago, Ralph would never have been able to handle significant managerial responsibility. He had always been bright, but terribly depressed and ineffective. His personal life was a mess—he seemed henpecked and miserable. But now, Ralph was obviously on top of things in a very nice way. No more wishy-washiness: he was straightforward and clear. Whereas Ralph used to be self-effacing to an infuriating degree, and would endlessly qualify everything he said, he now came across as appropriately thoughtful and modest, but confident. As they caught one another up on their personal lives, my friend noted that Ralph spoke about his wife with unmistakable pleasure and affection.

So impressed was my friend with this apparent transformation that he was moved to comment on it to Ralph and to ask how it had come about. "I had a very good psychotherapy," was the answer. "I found a shrink who helped me figure out the things I needed to know about myself." Thinking that he might like to refer somebody some time to a therapist who actually helped people, my friend asked the shrink's name and was surprised to learn that Ralph had been in treatment with me.

Now, besides being gratifying to me, what is of interest about this coincidence concerns the fact that the very helpful psychotherapy with me which Ralph described to my friend had consisted of only one visit! I remember it very well. When he came to see me, Ralph seemed very much as my friend described his being years ago—troubled and tentative. He talked about his general malaise, his problems at work, his marital difficulties, his fear that he was an inadequate father to his two children, and a host of related worries. He told me a bit about his background, hesitantly sketching out what I thought were probably some very shrewd insights about his mixed feelings toward a loving but somewhat dictatorial father, his conflicted identification with a quietly competent mother, and his anxieties about a younger sister who adored him.

After a time, I asked Ralph what he wanted to accomplish in therapy. He thought a moment, then answered in a way I could not possibly have foreseen. He said that what he would really like to do was to feel able to devote a year to studying guitar. Apparently, Ralph was quite a talented guitarist and passionate about the instrument. He could practice for hours without noticing the time go by. He played jazz and was good enough to sit in at clubs on open-mike nights; but he had never had any formal training, and he knew that his level of playing would improve enormously if he could spend a year consolidating his skills through study at a conservatory. He was pretty sure he could get into a good one.

Ralph did not know where this would lead; certainly, he did not expect to make a living as a professional musician, but he knew he wanted to take his guitar playing further. At the same time, he knew that to do so would mean earning no money for a while. His wife's small salary would not begin to support the family. They would have to use up their savings, and there was a very real possibility that Ralph would be unable to find another executive position when he reentered the marketplace. Ralph felt himself on the horns of an insoluble dilemma: he did not want to put his wife and children at such risk, despite their assurances that they would support him if he needed to drop out for a year; on the other hand,

he remained preoccupied, distracted, and upset because nothing in his life seemed worthwhile if he could not pursue his dream.

Listening to all this, I had the impression that Ralph was not really describing a choice he was trying to make. It was more that he was describing his reluctance to act on a choice that he had already made. It seemed clear that he felt he could not be happy without studying the guitar, and that he could not study the guitar without asking his wife and children to endure a certain amount of sacrifice and risk. I conveyed this impression to Ralph, and he agreed. I asked him if he felt he had the right to do what he wanted to do. He thought quite a while before replying, and finally said that he was not sure. Probably, he did; but, in any case, he was making himself and everyone else so miserable by *not* doing what he wanted that, practically speaking, there really was no good alternative. Still, he felt unable to act.

I said that there were certainly a great many relevant matters we could explore—how Ralph seemed to be looking for permission from me or some other authority; particular problems he had in balancing self-interest against a sense of responsibility toward loved ones; the special meaning that artistic creativity as opposed to business held for him; and so forth. If issues of this sort were making things more difficult than they needed to be, it would be very useful for us to investigate them together; but it was also important to keep in mind that no amount of self-awareness was going to change the circumstances with which Ralph had to deal, or the need for him to act, one way or the other, and to take responsibility for his actions. It might simply come down to a question of Ralph's having to accept that he had to do what he thought best under the circumstances and live with the consequences, not all of which were agreeable.

As I laid out the way I saw the state of affairs, Ralph kept nodding thoughtfully in agreement. Our time was about up, so I suggested that we arrange another appointment to continue to reflect and decide how Ralph might want to proceed. He agreed. But the next day, he called to say that I had given him a great deal to think about, and that for the moment, he felt he did not need to chat further. He would certainly give me a call when and if he did. Ralph

thanked me warmly and said that he would like to stay in touch, in any case. I asked him to please keep me posted.

A month or so later, he left me a message that he had decided to take the plunge, to study guitar, and that he thought things were going to work out. For a few years, I received occasional notes telling me that he was doing well. Eventually, I learned that he was back at work and enjoying keeping up on guitar. After a while, I stopped hearing from Ralph, so that my friend's report was a very welcome update.

DISCUSSION

I offer this anecdote to make a point concerning the goals of clinical psychoanalysis. In my view, Ralph's treatment was a successful clinical analysis, because for me, psychoanalysis is first and foremost a treatment method for bringing about life changes desired by the patient. Ralph identified his own goals, and he achieved them. Clinical psychoanalysis aims to provide therapeutic benefit for the patient via self-investigation—by making it possible for the patient to review and revise his or her customary ways of knowing, of experiencing and understanding his or her world. I think we have to acknowledge, however, that we have a way to go in spelling out the process by which this is accomplished—the mechanism of action of clinical analysis—and therefore, we have a way to go in spelling out, as well, the principles of how best to conduct a clinical analysis. Our theory of psychoanalytic process and technique is very much a work in progress.

Insight

I consider the insight that a patient gains in a successful clinical analysis very important—but as a means to an end: the end of providing the patient with, in his or her judgment, less distress and more satisfaction in life. It seems likely that Ralph's one session with me set in motion for him an extremely productive process of self-

investigation. He told my friend that it did, and I see no reason to doubt Ralph's claim. As Ralph put it, with my help, he figured out the things he needed to know about himself. That he apparently did a large part of the work privately, after our meeting, in no way invalidates the understanding he gained. Just because Ralph did not share his insights with me does not mean that he did not arrive at a significant measure of usefully expanded self-awareness. I am sure that Ralph's eventual understanding of himself was far from complete; but then, that's true for every analysand, no matter how many sessions with an analyst he or she has attended. "Sufficient unto the day" is the only judgment one can really make about the completeness of any clinical analysis.

To claim for a treatment lasting only a single session the status of a clinical analysis may seem very radical of me, even an uncalled-for exaggeration. Analysts who report successful brief interventions usually conceptualize them as psychotherapeutic rather than psychoanalytic (e.g., Gillman 1981; Reider 1955). At the same time, we know that Freud conducted any number of extremely brief treatments that he thought of as clinical psychoanalysis—not as psychotherapy, about which he was much concerned as a degradation of his method. Also, some analysts have advocated doing analytic work in stages, as needed, rather than aiming for a prolonged, once-and-for-all encounter (see Grotjahn 1963). My report of my work with Ralph describes the outset of an open-ended clinical analysis. Ralph knew that he could go further with me whenever he wished; in the event, that proved unnecessary.

I would say that we have every reason to believe that a significant part of the important learning that takes place in a successful clinical analysis never comes up for explicit discussion between analyst and patient. My experience over the years has led me to conclude that the distinction we have been used to making between a "transference cure," in which important mutative experiences within the treatment relationship remain unexamined, and a "psychoanalysis," in which they are adequately scrutinized during scheduled meetings, is based on an idealization of our capacities for objective self-awareness. In this respect, I regard Ralph's therapy as

an extreme instance of, and a particularly conspicuous illustration of, what is always true of a successful clinical analysis: namely, that both explicit and implicit learning takes place, both during and outside sessions.

Outcome Criteria and Clinical Method

For me, *the test of the validity of any understanding arrived at in clinical analysis is whether it yields therapeutic benefit.* No matter how compellingly a formulation accounts for the patient's experience, past and present, within and without the treatment relationship, and no matter how much conviction develops about that formulation on the part of analyst and patient, if the understanding is not accompanied by desired life changes for the patient, its validity is suspect, in my opinion. On the other hand, if a patient, like Ralph, experiences obvious and important, enduring dramatic improvements on a variety of fronts—in Ralph's case, diminished anxiety and depression, greater enjoyment of his marriage, increased effectiveness at work, amelioration of obsessional character traits, and so on—then the patient's claims to important and valid insight, no matter how it has been reached, have to be taken seriously.

Of course, I am very well aware of the many questions that can be raised about the approach I took in my one session with Ralph—concerning my technique, so to speak. For example, without knowing very much about Ralph, I explicitly offered my own perspectives to him, including the possibility that action, rather than prolonged reflection, might be in order. I am sure that many colleagues will judge that, far from engaging Ralph in a productive analytic encounter, I encouraged him to avoid analysis! In order to effectively discuss this objection, we would have to take up in detail such matters as the role of suggestion in clinical analysis, the participation of the analyst's subjectivity in clinical analysis and how it is best managed, the nature of optimal collaboration between analyst and patient—and, overall, the problem of obtaining evidence for psychoanalytic propositions. I certainly cannot begin to give each of these adequate

consideration in a single essay; and, although they are extremely important subject areas, and relevant to the topic of the goals of clinical psychoanalysis, they comprise somewhat separate considerations.

For present purposes, I would simply like to say that I find psychoanalytic theories in general, and theories of technique in particular, useful only insofar as they guide me to the conduct of a therapeutically beneficial treatment—-a treatment that results in *the patient's experiencing desired life changes*. When I apply this criterion to the features of customary analytic procedure, it is far from clear to me that many of them are always, or even occasionally, productive. It seems to me that an experimental attitude toward clinical analytic technique is called for. Certainly, I think we are in no position to impugn as nonpsychoanalytic apparently formidable results on the basis of their having been achieved through unorthodox methods—as happened in Ralph's case.

That said, I would add that in my experience, clinical analysis is an enormously effective therapy. For example, I do not immediately think of prescribing medications to a depressed patient; and that is because, in my experience, clinical analysis can be as fast, if not faster, than antidepressants in providing symptom relief, because clinical analysis can yield broader and more enduring therapeutic benefits than do antidepressant medications, and because clinical analysis—-properly conducted—-has fewer side effects.

"Therapeutic" Goals and "Psychoanalytic" Goals

Psychoanalysts, in defining the purposes of their work, often distinguish between "psychoanalytic goals" and "therapeutic goals." Therefore, my conception of clinical analysis, which is oriented toward achievement of life changes desired by the patient as *the* outcome measure, differs fundamentally from the conceptions of some of my colleagues. However, I have the impression that the priority I give to therapeutic benefit as the ultimate outcome measure for clinical analysis is completely consistent with the aims and interests of the great majority of potential analysands.

An analyst who defines psychoanalytic goals as separable from therapeutic goals brings upon him- or herself two important difficulties. The first is ethical and practical: In my experience, most patients seek therapeutic benefit, pure and simple. If they are interested in increasing self-awareness, it is only as a means to the end of feeling better in their lives. Therefore, an analyst who operates with some other, nontherapeutic goal in mind compromises his or her ability to meet the needs of the great majority of analysands and potential analysands.

The second disadvantage is scientific: If an analyst regards therapeutic benefit, *as experienced by the patient,* to be the primary indicator of successful analytic work, the analyst uses an outcome criterion that is relatively independent of his or her own theory and presumed expertise. On the other hand, so-called "psychoanalytic goals," that is to say, outcome criteria that are *not* based upon the patient's subjective judgment, are of necessity closely tied to the analyst's preferred theories (see, e.g., Gabbard, in press). When the goal of clinical analysis is defined in theory-bound terms, the analyst, who has superior knowledge of theory, will speak with a privileged voice in the assessment of clinical progress. In this case, the danger of circularity is increased: i.e., it is more likely that clinical work will ultimately consist of finding what the analyst has assumed a priori to be there.

Sometimes, the argument is made that pursuing "psychoanalytic goals" is the best way to achieve therapeutic benefit for the patient, but that claim must be regarded as mere lip service unless therapeutic benefit for the patient is used as the ultimate outcome criterion by which analytic success is judged—i.e., unless the test of the validity of any understanding arrived at in clinical analysis is whether it yields therapeutic benefit to the patient; and in that case, we cannot really speak of the pursuit of "psychoanalytic goals," separable from "therapeutic goals."

Collaborating on Goals

I want to underline that when the patient's experience of therapeutic benefit is used as the measure of analytic progress, it does not

mean that an analyst has nothing to contribute to the definition of the goals of clinical analysis and the assessment of progress toward those goals. Every seasoned analytic practitioner has known a patient to pronounce him- or herself cured while still apparently suffering, in which case it can be very useful for the analyst to confront the patient with what seems to the analyst to be a contradiction; or, to pick another kind of example, it is sometimes very helpful for an analyst to suggest to a patient who complains of lack of progress that he or she seems to the analyst to be trying, for one reason or another, to deny what appear to be therapeutic benefits that have accrued from analysis.

In other words, while it is true that the matter of therapeutic benefit—i.e., whether a patient feels more satisfaction or less distress in his or her life—is, ultimately, an epistemologically private judgment on the patient's part, it is also true that the analyst, an intimate observer, can have perceptions to offer for consideration that may be useful to the patient as he or she makes judgments about whether progress is being made toward the goal of therapeutic benefit. The main point here, in my view, is that the specific goals of a particular clinical analysis, and progress toward those goals, are not subjects about which an analyst knows more than the patient. On the contrary, definition of the goals of a particular analysis, and judgments concerning progress toward those goals, are matters for collaboration between analyst and patient—but matters about which the patient has the last word.

We have to take into account, as well, the obvious fact that there are two participants in the clinical analytic encounter, analyst and patient, and that each will, inevitably, have his or her own specific goals in mind, consciously and unconsciously. Sometimes, analysts' and patients' goals will be in conflict. Conflicts between patient and analyst about the specific goals of their work together must be resolved if treatment is to proceed successfully. My experience is that much can be learned from the examination of differences between analyst's and patient's goals, but that such differences, if they persist, will prove inimical to analytic progress. I think that too often, clinical analysis becomes a prolonged, profitless exercise pre-

cisely because a difference between analyst's goals and patient's goals remains unresolved. Sometimes, the difference is disavowed and never discussed explicitly; at other times, the difference is acknowledged, but underestimated as a problem.

One common mismatch between analyst's and patient's goals occurs when the patient is in analysis to achieve therapeutic benefit, while the analyst sees him- or herself as conducting a disinterested, free-ranging exploration of the patient's mental life. Another, related mismatch occurs when analyst and patient both pursue the goal of therapeutic benefit, but each has a different conception of what, specifically, would constitute therapeutic benefit—e.g., the patient wants to become less depressed by achieving more in life, whereas the analyst believes that the patient needs to relinquish narcissistic, grandiose expectations.

In my view, clinical analysis is an elective collaboration. The patient's goals are, and should be, paramount for the patient; and the analyst's goals are, and should be, paramount for the analyst. I find it crucial that both analyst and patient continuously clarify and explicitly discuss their goals. If at any point analyst's goals and patient's goals cannot be reconciled, neither should feel obliged to submit to the other's agenda. Nor should either analyst or patient feel obliged to continue in the work if, after time, reconciliation of goals cannot be achieved.

In other words, inasmuch as the analytic treatment relationship is an elective collaboration, neither party should be regarded as an authority on what the other's goals are or should be. The topic of goals, like any other topic in analysis, must be open to discussion and negotiation. Analyst and patient may very well influence one another's views about goals, but ultimately, each must determine his or her own goals. For example, since my own fundamental analytic goal is to provide therapeutic benefit to the patient, it often happens that I am willing to endure things in treatment that I would much prefer to avoid—and do avoid—in my private life. This happens when, as far as I can determine, my patient is being helped by what is going on between us, even if I am not enjoying it. Obviously, in such instances, while I may be submitting to my patient's

agenda in immediate and particular ways, the big picture is that for me to do so is consistent with pursuit of my own goals as an analyst.

On the other hand, it sometimes happens that a patient insists that he or she is benefiting from the treatment, whereas I, no matter how respectfully or thoroughly I consider the patient's point of view, cannot agree with his or her claim to progress. That condition rarely persists over a long time; but when it does, I consider terminating the analysis unilaterally. Thus, to my mind, therapeutic benefit for the patient is the goal of clinical psychoanalysis and the outcome criterion by which the success of clinical psychoanalysis should ultimately be judged. Assessment of therapeutic benefit is a matter for ongoing collaboration. Eventually, however, analyst and patient must each reach his or her own conclusions and act accordingly.

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Psychoanalytic Quarterly, LXX, 2001

THE TREATMENT OF AFFECTS: AN INTERDISCIPLINARY ISSUE

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Neither psychoanalysis nor psychopharmacology has as an immediate objective the treatment of dysphoric states, nor has either specified the treatment of guilt or shame among its primary goals. Certainly, among available medications, classes of anxiolytics and antidepressants are described; yet the prevailing assumption is that the cause of anxiety or depression is to be treated. Neither in psychoanalysis nor in psychopharmacology is it honorable to acknowledge that the *symptom* of the illness—rather than its *cause*—is being acted upon.

Psychopharmacologists often believe that the drugs they use act on the cause, and psychoanalysts consider affects to be a consequence and indicator of intrapsychic conflict. These perspectives continue to lend credence to the notion of a competition between the two treatment approaches and an incompatibility between them. However, it is specious to conflate the psychopharmacologist's view of affect with that of the psychoanalyst; the two therapeutic targets are not situated on the same level. While assuredly, the psychodynamic and psychophysiological perspectives take affects into consideration, the processes they observe are not situated in the same clinical realm or on the same observational terrain, and they do not constitute identical therapeutic objectives.

In itself, the clinical psychoanalytic mode of observation of affects has no particular specificity. It rests on the phenomenological

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This paper was translated by Ralph Eisenberg, Ph.D.

study of affects, precisely those found in clinical psychiatry in general, as well as in clinical psychopharmacology. It is by means of comparative and differential approaches that one describes the traits of anxiety, depression, or shame. On the other hand, the metapsychological model, the connection to the drive, and the disjunction of affect and representation are clearly psychoanalytic concepts; they have little in common with the psychopharmacological model. Yet how do we access them in psychoanalytic clinical practice?

AFFECTS IN THE CONTEXT OF CLINICAL PSYCHOANALYSIS

Two affective states are generally taken as typical expressions of affect in clinical practice. The first involves one or several sessions taken over entirely by a dominant mood state that seems to be the legitimate expression of at least preconscious representations. It is impossible to determine whether this dominant affect, which corresponds to the term *mood,* results from the dynamics of representations, or rather provokes them; the question in itself may perhaps be irrelevant. In the second instance, an emotion suddenly comes to the fore and pervades the associative flow. In these two instances, we have at our disposal particular terms, *mood* and *emotion,* to designate these affective states. Their clinical identification does not pose any dilemmas; it derives from common-sense psychology, and perhaps even the elementary mechanisms of communication.

The questions that I would like to raise concern fluctuations in affect that are perceptible only with great difficulty due to their fluidity and low intensity. The study of fluctuations in affect and their regulation in the course of a session can no longer be based on the description of conscious, subjective experiences or the "macroscopic" study of processes of change. Its point of departure must be the metapsychological definition of affect—that is, the mechanisms that depend on the intensity of drive movements and signals of pleasure-unpleasure. Preliminary questions involve the determination of the object to which this form of regulation is to

be applied: Does it concern every unconscious mental act? And to what does this notion of mental act refer on the clinical level? Further, how can one identify and even define the concatenation of psychic acts in the associative train? We have every reason to think that affects play a regulatory role with respect to the associative thought train, but we can construct only hypothetical models to describe this regulatory process. What is troublesome for us, moreover, is less the sequential chain of affects than the representational thought stream.

It is indicative of a naive realism to believe that we can clinically follow the train of successive representations unfolding in the analysand's mind. There are three equally important reasons for this impossibility:

> First, it is neither the representation nor the affect, properly speaking, that is the overriding factor, but rather what they represent, which is the drive itself. Now what do we know about the dynamics of drives in the context of the unfolding events of a session? We can only attempt to reconstruct those dynamics after the fact, either following the session or at a point during it when we endeavor to grasp the themes that have just been raised.
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> Second, the perspective of a linear sequence is a false one. At every instant, the mind of the analysand is occupied by a set of drives that contribute to the complexity of the mental state of the moment. Each construction after the fact can thus stem from a variety of sources and pathways, even if one of them expresses a dominant affect that alone might be accessible to consciousness. We must therefore recognize that affective dispositions waiting in the wings—"a potential beginning," to use Freud's expression (1915, p. 178)—are permanently present in the unconscious and preconscious systems.
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> The third factor that leads us to renounce a naively realistic view of the linearity of the representational and

> affective train is that the analysand's mental processes are inextricably linked to the representations and affects occurring simultaneously in the analyst. We are at every instant affected, on our part, by verbally expressed thoughts and their context, a network of affect-bearing representations. By a process of *cothinking,* our own associative train, the contextual environments accompanying it, and the affects thereby mobilized in us come to occupy our own conscious and unconscious mental stage.

But at the same time that these considerations incite us to forego a naive realism (which, it bears repeating, would allow us to believe that we can perceive, during the course of therapy, the sequences of drive impulses, and hence the affects linked to representations that successively arise), they open the way to a subjective perspective. It is in a retrospective fashion that we can discern the effects of the analysand's affects on and in our own mental state. In this manner, a network is gradually organized, one of potential representations and affects present in the associative flow of the analysand as well as in the analyst. An affect can supervene only when a drive impulse becomes active in the form of a psychic act. The environmental network of drive impulses involved in the psychic act of the moment is the carrier of potential affects capable of being activated at a given time, and it is these affects which—and here is the important point—are discernible as potential (virtual) elements providing access to the work of cothinking.

Full weight is given here to the notion of a psychic act, a term employed by Freud in *The Unconscious* (1915), in order to show how the drive impulse, the *trieb*, actualizes itself, and that it is the force of this actualization that is perceived as an affect. The psychic act is the actualization of a wish, and in particular an unconscious wish —or, in other words, unconscious fantasies. What we are able to observe is not only the force of the drive impulse thus activated, but also the effect of pleasure or unpleasure that this activation creates, in its relations both to other drive impulses that have been mobilized, and to the external environment. We come upon here what

Freud was considering in his attempt to define affects when he spoke of the association of the sensations of pleasure and unpleasure with the perception of an accomplished motor action.

At every instant in the course of treatment, a set of unconscious and preconscious drive impulses comes into play. Our constructions, made after the fact, privilege one or certain of these impulses, together with their related affects. To picture the process thus defined, one can refer to the analysis of dreams. Dream analysis is carried out after the fact when the dreamer narrates the dream, unraveling the associative threads that have contributed to the work of the dream's elaboration. Let us take an example from Freud himself, a dream that he felt exemplified the work of condensation—namely, the dream of the botanical monograph. His brief account of the dream (1900) is well known:

> I had written a monograph on a certain plant. The book lay before me and I was at the moment turning over a folded color plate. Bound up in each copy there was a dried specimen of the plant, as though it had been taken from a herbarium. [p. 169]

Apparently, the narrative of the manifest content was not accompanied by a strong affective charge; the action of leafing through the monograph seems to have been relatively devoid of emotion. But the affective situation is not the same when we follow the chain of associations; Freud's attitude could not have been neutral with respect to his relationship to Martha, the failure of his experimentation with cocaine, nor Fliess's view of the book in the process of being written. And what can be said about the residues of infantile memories that were scarcely evoked—the relationship to Freud's father, to his sister Anna, and so on? In short, the dream work, by condensing all these drive movements, in effect neutralized the affective charge, leaving an emotionally flat impression. Yet the evocation of the dream after the fact, and the associative work undertaken by Freud, reveal emotionally compelling representations. And —careful scrutinizers that we are—we cannot remain insensitive to the intense note of nostalgia that reading Freud's words makes

us feel, both in relation to his married life and to his scientific aspirations. Had we been present during the recounting of the dream, we might have been able to ascertain the force of the hostile feelings held toward Fliess well before the time that they were unequivocally expressed.

Our knowledge of affects during therapy does not proceed any differently. Behind the affect or the absence of affect at a given moment in the session, the associative trains of the analysand, together with our own, allow us to identify the latent affective charges. Consider the following:

> A patient comes to her session, remarking that she has arrived on time. Nothing permits the identification of any particular emotional charge. The remark is made in a lively way, or so it seems to me. On reflection, I form the impression that the patient seems rather satisfied. But what is she satisfied about—being on time, or pointing this out to me? I associate to the fact that she has recently been late several times and that she even forgot a session, unique for her. But beyond this, several associative trains come to mind: in particular, her wish to make me feel that her family difficulties had leveled off, and also that she might be challenging me for having announced that I would have to cancel the next session. Was the affect of pleasure related to one or the other of these representations? I observe that I am rather irritated by her satisfied expression, which shows that, from the viewpoint of countertransference, I favor the option, whether right or wrong, of pleasure in defiant challenge. But what followed in the session brought to my attention another associative train that I had not envisaged, one that concerned her experience of passive pleasure—for once stripped of all guilt—in an experience that she had had in the previous session.

This short and quite ordinary clinical vignette well illustrates the mental work of retrospective construction that affects oblige us to undertake. Doubtless it is the representations, those of the patient and my own—our transference and countertransference feelings, our memories held in common and yet differently rec-

ollected—that sustain the associative work that each of us has accomplished in a parallel fashion. The process of cothinking was set in motion from the initial moments of this session, and was mobilized by an affect that might be said to have served as a guiding "red thread" for the associative work.

> The patient's associations after her opening remark were indicative of a defensive stance, and were expressed by a train of thought that seemed to suggest her withdrawal from me. An affective tone of anxiety and then boredom seemed to me to mask an undercurrent of eroticization and conflictedness, brought forth by her recollection of the experience of the previous session. Had she felt my countertransference irritation (by some sign of which I was unaware, or by inferences based on past occasions)? And did she wish to flee a situation of potential aggression?

We see here that if the affect is identified by its relationship to the representations of which it is the carrier, then affective changes reorganize the play and interplay of psychic acts at every instant in time. But of this we become aware only after the fact—even though, at each instant, the psychic acts of the analysand and those of the analyst are interacting.

This clinical example shows us, moreover, that if the analyst's awareness of an affect induces a further awareness of the representations that give it meaning, then a heightened knowledge of that train of representations often permits the analyst to identify variations in affects that give life to the associative flow of the session. In the clinical case reported, I did not directly perceive anxiety or boredom in the patient; rather, it was the sequence of my own thoughts that allowed me to identify these affects by means of a process of empathy. It was by way of inference that I concluded that a process of inhibition was present; and, similarly, I surmised that I was witnessing the effects of the patient's inner withdrawal, which I interpreted as resulting from the effects of anxiety and then boredom. I came to this understanding by identifying with what the patient might be feeling. Furthermore, the pleasant tone of her ini-

tial remark came to mind after the fact, even though vocal or facial expressions may have played a role outside of my awareness.

It can be seen, therefore, that it is through empathy that we identify an affect, on the basis of the dynamics of the patient's associations and our own. This is what gives a subjective character to our knowledge of the patient's affects in the treatment setting. But this radically subjective dimension of empathy does not in any way detract from its value in gaining knowledge of another's affect.

If it is agreed that the study of affects in the treatment situation should address fluctuation in microaffects that at each instant accompany and regulate the associative thought stream, it is necessary to specify the nature of this process and the clinical modalities that will give us access to it. A rigorously empirical viewpoint would require that we first consider clinical data, prior to examining metapsychological hypotheses. I think, however, that the theoretical model one adopts directly influences the clinical method applied and hence the data obtained; this is, at least, what I shall try to demonstrate.

FLUCTUATIONS IN AFFECTS: A METAPSYCHOLOGICAL VIEWPOINT

Affects fluctuate as a function of the representations that underlie them. Associative connections bear on representations. An initial hypothesis might be to consider that an affect is nothing more than the subjective quality of the representation. It is a thought that would make one sad, for example, and a succession of thoughts would regulate the sequence of affects. An affect would have merely a regulatory function, that of serving as an indicator of the quality of each representation. This position disregards entirely the economic point of view, and applies to microaffects what we observe in the phenomenological approach to affective states and emotions.

Drive theory since Freud has considered the dynamic nature of the associative flow as stemming from biological drives, of which affects are taken to be the direct expression in the same way as are

representations. According to this view, the observation of fluctuations in affect—paralleling that of representations—affords the indirect study of drive dynamics. The metapsychological construction proposed by Freud, in introducing the quantum of affect as the expression of drive charge, appears to be highly theoretical and dependent on a monophysiological theory of drives, which has been subject to criticism from many quarters.

One is led to question also a phenomenological standpoint that does not at all explain the dynamic source of affective variations, and to question as well the neurophysiological point of view, which seems to present a highly abstract model, one considerably removed from the clinical course of oscillations in affect. Therefore, we must consider affect not as the subjective quality of a representation, but rather as the expression of its dynamism, on the condition that representations be viewed as psychical acts.

To illustrate this viewpoint, let us take as an example affects in dreams, related either to the manifest or the latent content. Consider, to begin with, the dream's hallucinatory character. In the dream, we witness the actualized realization of a depicted scene. This scene is, of course, the product of displacement and condensation, yet it is connoted by an affect that is pure. There are two reasons for this: first, the affect is often linked to a part of the latent representations. In therapy, dream interpretation generally addresses the reestablishment of a connection between the affect and this latent content. Second, the affect characterizes the movement induced in the dreamer's mind by the produced scene. There is always movement in the dream, whether fleeing, attacking, or simply contemplating; and in the dream, the scene depicted, by its hallucinatory character, mobilizes the subject, and the accompanying affect reflects this mobilization.

The hallucinatory character of the dream is related not only to the process of visualization, the iconic representation of thoughts—it is linked to the repetitive, abreactive function of dreams. Day residues and infantile memory traces are not, properly speaking, recollections, but rather events reexperienced in the dream. Both push for the enacted repetitions that constitute the dream ex-

perience. The remembering of this experience transforms into a narrative what previously was an action in a scene. It transforms a relived experience into a memory, although not without the recounting of the dream stimulating the affects involved.

The therapeutic situation offers us a model consonant with that found in the dream. A memory that is nothing but a memory could not mobilize an affect; it can do so only because, by becoming actualized through recall, a repetition of the event occurs on a smaller scale, mobilizing an action and awakening an affect. What prompts the subject to talk is in part the need to abreact the event.

If one follows the two models of the dream and the psychoanalytic treatment setting, the unconscious must therefore be the source of this hallucinatory reliving of an action. All the characteristics that we recognize in primary process ideation constitute properties of action. One can hypothesize that unconscious representations, or at least those involved in neurotic conflict, actualize and realize the hallucinatory evocation of a scene. The meaning of the concept "thing presentation" might be illustrated by the hallucination of an action.

For example, if a patient says, "It bothers me to tell you that my mother refused to come and see my apartment," what may we conclude about what is disturbing the patient? The act of telling me? Not really, as she has also let me know that my silences must reflect a lack of curiosity about her. In reality, thinking about this event amounts to being once more in the actual experienced situation of the previous day. There is nothing magical in this evocation, which keeps a dimension of reality, nor in the action that is prolonged by it: the apartment and the mother are still there. The scene evoked has not been completely brought to a conclusion, since the protagonists are still present. There is nothing astonishing in the fact that the action thereby prolonged maintains the persistence of the affect of disappointment. It is the affect's actualization that mobilizes a reaction of unpleasure and a defensive attitude.

One can clearly see here what is meant by "the affect is linked to an action." A representation that would have completely effaced the repetitive force, that would have truly become nothing more

than a mere narrative, would no longer mobilize the corresponding affect. This is evidently not the case in obsessional isolation—where a break is effected, but only at the price of the permanent cathexis of a fantasy scene in the form of an unconscious, hallucinatory (psychic) act and as a compulsion. Affectively charged thoughts that are expressed in therapy, and those that organize themselves in formations in the unconscious and in substitute formations in neurotic states, mobilize a repetition of action in the form of abreaction. Interpretation and associative elaboration are employed in order to reinforce the declarative dimension of the representation at the expense of this abreactive dimension, and thus tame the affect.

AFFECTS IN PSYCHOANALYTIC COMMUNICATION

Affects play a decisive role in the regulation of the microprocesses that take place during sessions. It has been noted earlier that in this respect, one can see the effects of empathy at work. It now remains to outline how this empathic effect functions in the therapeutic setting.

The mental states that succeed each other in the course of a session, ready to rise at the evocation of an associative chain, create a complexity that requires an interpretive framework, a choice in the focus of attention directed at processes that overlap and intermingle with one another. This choice does not depend on the analyst's conscious volition; rather, the analyst must recognize that he or she is moved (both emotionally and in the sense of having his or her thoughts set in motion) by the analysand's thoughts. It is this dual task of discerning affect in the other's mind, as well as in our own, that we must accomplish.

It is here that the idea of intersubjectivity comes to the fore, already present in Freud's interest in telepathy and in numerous of his discussions with Ferenczi. With the purpose of avoiding, at least partially, the equivocalness of this term, I propose the alter-

native *cothinking* to describe the effects of the analysand's associative processes and representations on the analyst's associative processes and representations. To the extent that a reciprocity exists by way of verbal and nonverbal expressions, and in order to take into account the fact that this transmission is situated in a domain beyond words, one might say that the "speaker's" speech, which results from the extraction of meaning that has its origin in a given mental state, enters the "listener's" associative system of representations. These elements, which have become an active source of thought in the listener, will either be integrated into an associative context proper to him or her and at a distance from that of the speaker, or will contribute to the construction of a common semantic context. In the first case, an effect of distancing occurs, but this may also prove to be a later source of enrichment for the common semantic context. In the second case, the effects may be nil (a too great associative closeness may testify to transference-countertransference collusion), or a favorable framework for interpretation may be created.

The term *cothinking* is intended to depict a process involving the reciprocal development of associative activity. Words—and what is signified by their interrelationships (their associations, omissions, censoring deletions, and so on)—that come from the utterance of one member of the therapeutic dyad enter the thoughts of the other, becoming the other's own objects of thought. The effect of the meaning that they produce depends on the associative context from which they are extracted. This applies equally to the speaker and the listener. The effects of distance and closeness that have just been evoked testify to the construction of an associative network in the mind of the listener, either different from the speaker's or shared in common. Words refer to something beyond language: the associative context, or in other words, the organization of the system of representations implicitly present in a verbally expressed proposition (Widlöcher 1993).

Empathy is not a mechanism in itself, but rather a process of communication. Freud placed an emphasis on the process of identification. To be able to "enter into someone's feelings without being involved emotionally," to use Greenson's (1960, p. 418) defini-

tion, we must imagine ourselves to be in that person's place. What then occurs is a partial and temporary identification carried out intentionally (but not necessarily consciously). This imaginative construction of an other's subjective experience requires the deployment of inferential processes. It is because I can represent to myself the contextual universe in which an other's conscious or unconscious thoughts are developed that I am able to identify with him or her (Buie 1981; Widlöcher 1993).

In the example given by Greenson, it is the patient's affect that incites the analyst, in order to give meaning to the affect, to put him- or herself for a time in the patient's place, and to reconstruct the context in which the moment of recollection occurred that brought on the affect. For example, the analyst may understand a patient's tears to be stimulated by the recollection of an evening gathering in which she felt isolated and alone. And yet, very often, it is—conversely—by means of empathy that we are able to identify an affect. Think of the effect induced in the reader by Freud's self-analysis of the dream of the botanical monograph.

The associative process of cothinking affords the possibility of the realization of an effect of empathy. Thanks to mechanisms of identification and inference, the analyst's associative work may permit him or her to construct a representation close to the analysand's mental state. We have seen that this closeness is not necessarily an assurance of analytic understanding, and one may be even less inclined to consider this closeness as entailing a therapeutic action in itself. I shall even propose the term *negempathy* to characterize those moments in which there is a divergence in cothinking, and where the representations forged in the analyst's mind move away from the analysand's associative network. This negempathic effect is always instructive, either because it informs us of a distancing, or even a flight, from the analysand's thoughts (via countertransference avoidance, effects of projective identification, simple distraction, or the like), or because it puts us on the trail of an unconscious process and stimulates interpretative work.

The empathic knowledge of affect functions in somewhat different ways, according to the manner in which the analyst hears

the analysand's words. We can privilege three different modes of address, depending on whether we take the analysand's words to be a narrative (the narrative dimension), a manner of addressing us (the transference-countertransference dimension), or a state of associative reverie (the regressive, dreamlike dimension). These dimensions are not independent of each other. The same utterance may be heard in terms of all three dimensions—that is, as the narrative of an event or a mental state, as a means of addressing the analyst, and as an almost dreamlike production.

Empathy allows us to identify not only the conscious thought of the present and its affective charge, but also, and especially, the associative context in which this thought is embedded. Not that we analysts could consciously represent this context; this can be done only partially, after the fact, when we attempt to retrace the course of a session. But it creates in the analyst an associative context that is in resonance with the patient's. It is the interplay of these two associative processes that permits us to follow the movements in affect that succeed each other over the course of a session. It is in this way that we are empathic, not only with respect to present experience, but also in relation to what that experience is connected to, and thereby to what may prolong or interrupt current, ongoing experience. In this way, we become cognizant of the regulation of the flow of affects in the analysand, as well as of our own regulatory and associative processes.

In this discussion, we are quite distant from dominant moods and shocking emotions. It is the dynamics of the associations, which is to say the representational flow, that allow us to divine the micro-affects accompanying them. We are also equally distant here from the affective states on which medication acts.

AFFECTS AND MEDICATION

A further issue that remains to be considered is the mode of drug action. At least two categories of psychotropic drugs act on affects: anxiolytics and antidepressants. Independent of a description of their

mode of action on the brain (which is beyond the scope of the present discussion), there is an important issue regarding the effects of these drugs on the regulation of affects, an issue of interest to the psychoanalyst on at least two counts. The first is practical in nature, and concerns the relationship and interaction between psychoanalytic and drug treatments. The second is theoretical, and addresses this question: How can the relationship of psychodynamic and biological mechanisms of the regulation of affects be best understood?

The psychodynamic effects of psychoanalytic insights bear on *fluctuations in drive impulses,* facilitated by the partial lifting of defensive processes and the greater tolerance of affects. The effects of medication involve *general processes of activation and inhibition in psychic life,* which Freud took into consideration under the term *generalized inhibition.* In *Inhibition, Symptoms and Anxiety* (1926), he wrote:

> The more *generalized* inhibitions of the ego obey a different mechanism of a simple kind. When the ego is involved in a particularly difficult psychical task, as occurs in mourning, or when there is some tremendous suppression of affect or when a continual flood of sexual fantasies has to be kept down, it loses so much energy at its disposal that it has to cut down the expenditure of it at many points at once. It is in the position of a speculator whose money has become tied up in his various enterprises. [p. 90, italics in original]

This certainly applies to anxiety defined as a state of expectancy without a specific action to put an end to it (see Widlöcher 1986).

What I wish to underscore here is that a similar but not identical mechanism obtains in depression. Freud had already noted this in *Mourning and Melancholia* (1917):

> The complex of melancholia behaves like an open wound, drawing to itself cathectic energies—which in the transference neuroses we have called "anticathexes"—from all directions, and emptying the ego until it is totally impoverished. It can easily prove resistant to the ego's wish to sleep.

> What is probably a somatic factor, and one which cannot be explained psychogenically, makes itself visible in the regular amelioration in the condition that takes place towards evening. These considerations bring up the question whether a loss in the ego irrespectively of the object—a purely narcissistic blow to the ego—may not suffice to produce the picture of melancholia and whether an impoverishment of ego-libido directly due to toxins may not be able to produce certain forms of the disease. [p. 253]

Freud further commented on this subject in *Inhibition, Symptoms and Anxiety* (1926), in which, after having cited the case of a transitory generalized inhibition in a patient suffering from obsessional neurosis, he returned to melancholic inhibition: "We have here a point from which it should be possible to reach an understanding of the condition of general inhibition which characterizes states of depression, including the gravest form of them, melancholia" (p. 90).

I suggest that what depends directly on the integrated neural network targeted by drug treatment is not the fluctuation of affect as such, but rather a dominant mood that is the consequence of a basic emotional response. Following in the steps of Engel (1962), Joffe and Sandler (1967) described this as the central depressive response:

> The central depressive affective response was thought to be a fundamental psychobiological response which could perhaps be conceived of as being as basic as anxiety. In our view the basic affective response appeared to have its roots in a primary psycho-physiological state which could be regarded as a response to the experiencing of helplessness in the face of an intolerable internal situation. There may be grounds for considering the depressive reaction as a particular sort of "last-resort" attempt at adaptation to helplessness in the face of an unbearable state of affairs; a form of adaptation in which all bodily and mental processes are, so to speak, "damped down." It reflects to a varying degree, the state of helplessness, hopelessness and resignation.

> Such basic depressive reactions can also be seen to occur in response to intolerable states of strain in adults as well, and are not to be confused with those forms of depressive illness (such as certain forms of melancholia) which can be considered to be consequences of further defensive and restitutive processes, and in which pathological introjections and identifications occur. [p. 72]

I propose that what we call *psychomotor retardation* or *inhibition* is the symptomatic expression of this alteration in the mode of execution of programs. This alteration is characterized by a delay in incitement and a slackening in the incentive to act, whether the action involved is in the motor or verbal domain or in the domain of thinking. At present, a series of research studies are focused on this mechanism, which is of a different order than the sequences of thought described by psychoanalysis (Speech Pause Time, Motor Activity Monitoring, Depressive Retardation Rating Scale). This slackening or loss of incentive to act may have its basis in the disappearance of reinforcements linked to the loss of the experience of pleasure or to a neurophysiological mechanism, and it may in time create an experience of loss. It is therefore possible to conceive of a system in which the causal relationships between different mechanisms may be established in opposite directions.

Certainly, much remains to be done to better define, and to encourage psychoanalysts to accept, the indications and limits of the therapeutic applications of psychoanalysis. When all is said and done, it cannot be sufficiently emphasized that in contrast to other psychotropic medications, antidepressants relieve the intellectual inhibition linked to psychomotor retardation.

I should like to conclude this part of my discussion by particularly stressing the following points:

> It would be useful to more precisely specify, for each form of pathology, qualitative and quantitative indicators permitting us to evaluate the danger of passage from a state of vulnerability to depression to a depressive condition.

It will be important to better define the objectives and techniques of focal psychotherapies applicable either to these predepressive states of vulnerability or to those states that typically follow a depressive episode which has been treated pharmacologically.

Finally, I should like to emphasize that despite—-or perhaps because of—the considerable therapeutic results obtained with drugs, the drawbacks of long-term pharmacotherapy have perhaps not been given the attention they deserve. These drawbacks should nevertheless oblige us to consider more attentively the positive results that may be obtained through a psychological approach to treatment.

CLINICAL ILLUSTRATION

Mr. B, in his thirties and single, consulted me about undertaking an analysis. Following several unsuccessful attempts at psychotherapy, he had arrived at the decision to pursue analysis because of his protracted difficulties in maintaining an enduring relationship with a woman, and because he had repeatedly suffered from depressive episodes, which had necessitated several courses of antidepressant medication.

A biologist with a specialization as a pharmacist, Mr. B had had excellent professional success. He stated that he was deeply self-centered, with scant interest in others except insofar as he could be the object of attention and admiration from his numerous male friends. About two years into treatment, and for the first time since the beginning phase, he complained about being depressed once again, a state that manifested itself in pronounced hypochondriacal concerns, a pessimistic view of the future, and a feeling that he should give up the analysis because of his incapability to utilize it. He had initially committed himself to analysis with enthusiasm, rapidly developing a seemingly highly positive transference relationship, idealizing the analyst and "doing his best" to live up to what he believed was expected of him in the analytic situation. Attitudes of

grandiosity and self-doubt alternated as a function of changes in his mood related to ordinary events in his everyday life.

The session of which I shall report the first ten minutes was the initial one of the week, following Mr. B's return from a weekend in the country, which he had spent at a younger male friend's house. When Mr. B entered my office, I noticed that his expression was withdrawn and tense, and, in contrast with his usual habit, he did not smile. I felt that he was hostile and supposed that, as had been the case for the previous several weeks, he must have been wondering about the usefulness of continuing the analysis, which had not kept him from becoming depressed yet again. (Of course, I remained very neutral when he attempted to get my opinion about the relative merits of resorting to medication.)

Mr. B lay down on the couch, sighing, and remained silent for several minutes. I was concerned about his initial attitude on entering, one which I had not seen in him up until then, and, fearing that he would use the session to defensively undo a negative movement in the transference, I encouraged him to speak. He wondered aloud why I so quickly sought to interrupt the silence. He had noticed, he continued, that customarily, I did not intervene. I pointed out to him the hostility that appeared to have taken hold of him before he lay down. He refuted my interpretation of hostility and told me that his silence had been due to the fact that he did not wish to air, once again, the usual complaints about his problems. He disliked himself for always repeating the same thing to me. Then he became visibly troubled, and alluded to a thought of an entirely different nature that was even more disturbing to him. I thought of his shame in talking during earlier sessions about his anal masturbation, and, I supposed, in thinking of the homosexual fantasies that must have accompanied this.

After several moments, Mr. B remarked that I was probably more interested in his sexuality than in his "psychological" problems—because of my professional training that had deformed my outlook. He then told me that during his stay with his friend, he had thought about the topic of small penis size. After some general comments, he came around to the following specific event: In

looking at his friend while the latter was changing to play tennis, he saw through his underpants the voluminous mass of his genitals, and this had reawakened in Mr. B his anxiety concerning his own penis. The heightened interest in sex that he attributed to me, as well as his interest in his friend's penis, were probably acting on me, as I heard myself say rather easily that he was perhaps somewhat "excited" at seeing his friend's genitals; and, doubtless to attenuate the clearly homosexual implication, I thought it useful to remind him of the reference bearing on the connection to penis size.

Mr. B undoubtedly saw the ambivalence in my intervention, since to my great (and naive) surprise, he picked up on this while at the same time taking me to task by stating that he knew very well that he had a normal penis—in fact, rather above average in size, something about which he had reassured himself since adolescence by means of comparisons, observations, and the reading of anatomy books. Instead of addressing the idea of excitement to which he had also admitted and that he had made available to an intervention further down this associative line of thought, I contented myself with what he had offered to me as a lovely illustration of splitting, something that interested me at the time on a theoretical level. I felt at ease in pointing out to him this splitting process, with which he evidently agreed, and he was happy to share with his analyst in this way his more theoretically oriented knowledge.

However, immediately thereafter, rivalry with the analyst claimed its place in the therapeutic relationship. He told me that for about a week, he had resumed taking antidepressant medication, and that, contrary to what psychiatrists and psychopharmacologists are apt to say, certain favorable effects appeared much earlier, probably due to the anxiolytic effects of the inhibitors of the reception of the substance. He seemed happy to make this observation (and to tell it to me). At this moment, I had the disagreeable feeling of being kept at a distance. The remainder of the session was occupied by a more run-of-the-mill and better controlled description of what had gone on over the weekend.

This clinical sequence seems to illustrate three points quite well:

> It is fairly common that we find ourselves in a situation in which the analyst is unable to clearly identify the patient's relevant affective state, so as to evaluate either the appropriateness or the possible effects of medication. Consciously or unconsciously, we are sensitive to the flow of microaffects that occupy the analysand's mind, as well as our own minds.
>
> The effects of empathy and negempathy alternate as a function of countertransference and the effects of projective identification.
>
> Microaffects result from the psychic states of the moment (conscious, preconscious, or unconscious), and play a determining role in the analysand's and the analyst's associative processes, as well as in the interaction of these processes. To review, I have proposed that we call this interaction *cothinking*.

CONCLUSION

The issue of affect is relevant both in the initial stage of the seeking of treatment, and when it comes to assessing treatment effects. Drug action does not permit the appreciation of a difference between the two: the dysphoric state about which the patient complained is clearly the target of medication. Yet the same does not apply to psychoanalytic treatment. It is true that the initial treatment goal defined by the patient described above was to find a remedy for his dysphoric state; yet the therapy's objectives were not directly related to that state. Rather, the aim was the achievement of greater freedom in the patient's associative processes and movements, as well as the patient's development of insight—not only with respect to the representational world, but also in regard to the world of microaffects that regulate the time course of the asso-

ciative stream. A further aim was to surmount the inhibition that may be produced by these microaffects.

This is the specific level addressed by all psychoanalytic treatments. It is different from that targeted by medication, but allows for clinical treatments that are complementary to it.

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Psychoanalytic Quarterly, LXX, 2001

WHEN THE FRUIT RIPENS: ALLEVIATING SUFFERING AND INCREASING COMPASSION AS GOALS OF CLINICAL PSYCHOANALYSIS

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In my view, there are two main objectives for a successful psychoanalysis or long-term psychoanalytic psychotherapy: the gain of a perspective and skill that alleviate personal suffering during and after treatment, and an increase of compassion for self and others. Although my own training is Jungian, I have for many years practiced in institutions and settings that were mainly Freudian, object relational, and/or intersubjective. In the following account, I mean to speak to these goals in ways that are common to all analytic approaches. I feel passionately committed to clarifying the goals of psychoanalytic practices in terms that can be readily understood by those who need therapeutic help in this age of managed care and biological psychiatry. I hope that this essay sets out such terms in a framework that also lends itself to scientific study.

In the following account, I will give definitions and descriptions of suffering and compassion, and show how and why the transformation of suffering, through psychoanalytic treatment, should lead to gains in psychological well-being that last a lifetime. Knowing how to alleviate one's own suffering presumes some insight into human suffering in general, and an ability to hold open certain experiential moments of emotional meaning which would otherwise trigger impulsive reactions that may be expressed internally, externally, or both. Such impulses are felt as pressure or anxiety, and are experienced in adults as habitual patterns of action, thoughts, and affects. These habit patterns are largely the product of early relational and

emotional conditioning, trauma, abuse, or other adversity, in a particular person (referring to embodiment and socialization) and a particular interpersonal environment.

COMPLEXES AND PROJECTIVE IDENTIFICATION

Jung called these emotional habit patterns *psychological complexes,* and regarded them as the fundamental structures of personality. The ego complex (activated by the self-conscious emotions) is the most conscious among multiple centers of subjectivity. Less conscious complexes may be dissociated from conscious awareness or partly conscious; they may be projected into others or wholly identified with at a particular moment (for a further discussion of these ideas, see Young-Eisendrath 1997 and Young-Eisendrath 2000).

When a person identifies with an unconscious complex, we say that she is "beside herself" or that he is "not himself," and most people recognize this kind of not-self state in their own emotional landscape. From time to time, anyone can lapse into such a state, filled with unconscious or semiconscious emotional meanings, and unknowingly invite another or others to play out aspects of the first's inner emotional drama. If another person unknowingly takes on the projected or implied meanings and acts on them, or plays them out, or seems to play them out, the original initiator of such a "projective identification" may feel temporarily relieved of unconscious pressures and fantasies. Jung's term for this was *participation mystique,* an expression he borrowed from the anthropology of his day.

Projective identification is, in my view, a ubiquitous form of protocommunication that causes a great deal of suffering in individuals, relationships, families, groups, and communities—both in terms of what is projected, and what is identified with and then played out. And yet, projective identification is also a healthy and ordinary component of human relationships and family life, necessary for certain merger states of sex, care, and love. It is probably also a contributor to the development of emotional attunement, sympathy, and empathy, and a component of hatred and ali-

enation as well. Momentarily or temporarily losing aspects of oneself can be a healthy part of relational life with other people. However, permanently or regularly losing parts of one's identity or experiences through chronic projection, identification, or dissociation is a major component of most psychopathology, and creates suffering in relationships, work, and meaning-making.

Achievement of the goals of alleviating suffering and increasing compassion depends on an ability to recognize one's own habitual impulses to dissociate, project, and/or identify with some alien emotional meaning, and then to sidestep or hold open that impulse so that something new (which is not part of the old emotional script) can emerge. The capacity to hold open one's subjective experience during a moment of habitual pressure to react is called the *transcendent function* in Jung's (1969) terminology, *potential space* or *play space* in Winnicott's (1971) vocabulary, and *dialogical space* in Ogden's (1990).

As I explain below, this capacity to hold open emotional meaning becomes a skill of the patient's during the course of a successful psychoanalytic treatment. In order to achieve such a skill that can be used in everyday emotional engagements with oneself and others, a patient must have gained more than insight; she or he must have developed compassion for self and others. Without such compassion, there tends to be confusion and self-condemnation about the insight gained through analytic treatment.

The capacity to transcend and transform one's suffering in the moment of its occurrence is the fruit of a therapeutic endeavor that interprets transference and countertransference, as well as other relational patterns and dream imagery, and achieves insight into harmful habit patterns. The context in which this insight ripens into an ongoing skill—the skill of using the transcendent function or dialogical space—is a vital, empathic, and creative relationship between a trained and well-attuned analyst/therapist and a suitable patient. In such a case, both patient and analyst will come to experience new freedom from old emotional habits, while the two concentrate their primary commentary and attention on the habit patterns of the patient.

All forms of psychotherapy share the common aim of alleviating human suffering, a term I will define momentarily. The effects of therapeutic interventions will, however, be transient and unreliable if the patient is unable to use the therapeutic skills gained at times when complexes and/or projective identifications become troubling in daily life. Analytic forms of therapy—designed to study unconscious motives, conflicts, impulses, drives, and repetitive, affectively charged complexes *in the moment*—offer the unique possibility of cultivating self-reflective skills in the face of emotional pressure. These skills, as I will describe, depend upon self-knowledge—-the ability to analyze oneself when triggered into a troubling habit—-and compassion for self and others.

All of these are outgrowths of expectable changes in the conscious attitude or perspective of the patient, but also include expectable shifts in the attitude of the analyst. I will describe this process in detail after I define and describe suffering and compassion in light of psychoanalytic (to include Jungian) methods.

SUFFERING AND INSIGHT

I define human suffering as a state of being that is off center or out of balance, and that is experienced as anguish, distress, discontent, anxiety, or agitation. This kind of subjective disturbance may be as mild as a momentary frustration (for example, annoyance over a hangnail or a traffic jam) or as severe as a depressive or psychotic state. In the way I am using it here, I mean *suffering* to refer to mental anguish that may be expressed physically in somaticized symptoms, and/or interpersonally as disturbances in relationships, and/or intrapsychically through distressing images and fantasies of self and other or self and world.

We (human beings) create this kind of subjective distress through perseverations, distortions, fantasies, and internal commentary, much of which is linked to our omnipotent longings and desires. We suffer a good deal when things do not go our way—the way we believe they should go—from resultant feelings of fear, humiliation, shame, rage, and despair. An adult's longings for omnipotence and omni-

science will have been profoundly, but unknowingly, shaped by the conditions in which she or he grew into a conscious person. These longings will have been affected particularly through ongoing emotional conditioning, as well as trauma, abuse, loss, illness, accidents, and other factors that were authentically outside of personal control.

For purposes of my discussion here—and because in other ways, I find it useful as well—I draw a distinction between suffering, as a state of being that can change through a change in awareness, and inescapable pain or adversity over which we may have little or no actual control. Of course, suffering and adversity interact in our experience: often we increase our suffering by wishing, wanting, or trying to stop situations or events that lie outside our control, and then find ourselves locked into shame, rage, or despair because we cannot. On the other hand, we may fail to carry out, or avoid, effective intervention in situations that cause pain and/or adversity because our suffering prevents us from feeling ourselves empowered and able to intervene on our own behalf. The confusion between pain and *suffering*, in the way I am using the term here, can also result in anxiety and depression over the constraints and limitations of one's life.

Ordinary examples of these feelings arise in everyday relationships with family members or life partners whom we long to control. All of us—but perhaps especially those who have already endured overwhelming insults and adversities—find it difficult to accept the limitations of human life. We also find it difficult to understand the responsibility we do have, and to feel and be accountable for our own intentions, feelings, and actions. Schafer (1992) described the distinction between human action and "happenings" in the following way, which I find helpful:

> In its broad sense, [human] action refers to far more than overt behavior; it refers as well to whatever it is that people may be said to do, and in this respect it stands in contrast to *happenings*, those events in which one's own human agency plays no discernible or contextually relevant part (for example, a rainstorm or receiving a misaddressed letter a week late). Among the things that people do is per-

> ceive, remember, imagine, love, hate, fear, defend, and refrain from overt activity. In psychoanalytic discussion, special emphasis is . . . placed on what people do unconsciously and conflictually (fantasize, remember, love, defend, and so forth). [p. xiii, italics in original]

I believe that insight into our own motives, memories, and actions, as well as knowledge of our early emotional conditioning, gradually allows us to discern the differences between our actions (and hence our responsibility and freedom) and happenings or events that lie wholly outside our control. This insight eventually clarifies the boundaries and domain of suffering that can be affected by a change in our understanding and attitude, as distinct from pain and adversity that cannot.

In a successful analysis, patients come to recognize what they generally have, although not completely, in their own control, as well as what they do not. Once this distinction is even somewhat clarified, the patient has a new freedom: the freedom of personal accountability. This includes an acknowledgment that one's subjective life—images, feelings, thoughts, and actions—is complex and malleable, as well as responsive to various kinds of reflection. One sees that one can choose to act in this way or that, that one can choose to regard things in this way or that, even when one is strongly drawn into an old destructive habit.

After such insight is fundamentally secured, it appears that a patient (with her or his analyst) faces two major emotional challenges: the challenge of living in the present with these new degrees of freedom, and that of regret and sadness for not having seen and lived this way sooner. For example, a patient in her late fifties sees that she has, over many years, unknowingly blamed others—especially her husband, her children, and her mother—for her (the patient's) lack of career achievements. She has rationalized the blame and resentment through idealized images of her children and their potential accomplishments. When her children seemed unable to satisfy their mother's hidden desires for power and success, this woman sought psychotherapy with me, saying she was "depressed" and "lacked interest in life." Eventually recognizing her ideals for

her children as compensating for her sense of lack in herself, and her attacks on her husband and her own mother as projections of aspects of her own inner conflicts, this woman faced the problem of having "wasted years." She felt herself in a double bind: damned if she accepted responsibility for her own development (condemning herself for not having "seen it sooner"), and damned if she did not (continuing to feel like a victim of her life circumstances).

Refining this encounter with her own responsibility, she and I came to see that her double bind was, in fact, her attempt to destroy some of what we had discovered together in her treatment. Throughout, she had assumed I was a "career woman" who never struggled with personal doubts about my abilities or powers. From the beginning, this perception of me (one that her mother would have shared) set me apart from her, and expressed an unconscious desire to keep me under her control, to make me be someone different from her. The patient finally saw that the alternative to her envy and idealization of my career was not to become alienated from me, as she had feared, but to trust that I could be supportive of her in her own career development. And yet, neither of us could know what would happen until she tried "going out into the world" herself. Eventually, she did just that, and was remarkably successful.

The patient eventually saw that her suffering had been created through her own desiring, fantasizing, aggrandizing, and diminishing of both objective and subjective events and experiences she encountered. When suffering extends beyond momentary frustration, it seems to swallow up our satisfactions, hopes, and interests. Often, this kind of anguish is experienced as self-loathing, self-hating, and/or revenge in the form of dominance/submission fantasies or enactments.

Freud and Jung and other early psychoanalytic practitioners and theorists spent the better parts of their careers investigating transient, repetitive, and permanent states of human suffering, and other seemingly irrational aspects of everyday life (e.g., dreams). They discovered something that now seems to be largely forgotten in our contemporary era of biological psychiatry and genetic reasoning: that even seemingly meaningless actions (for example, the

compulsion to repeat self-destructive experiences) could be best understood as intentional and purposeful from the perspective of implied but hidden desires and motives. The strangest and most troubling of human actions can be rendered meaningful when certain developmental facts are known. As contemporary psychoanalyst Strenger (1991) wrote:

> . . . the fundamental step which Freud took at the beginning of his career was to radicalize the principle of humanity and to apply it to phenomena which were previously exempt from it. Neurotic and psychosomatic symptoms began to be seen as humanly intelligible rather than as phenomena which were only amenable to physiological explanation. [p. 62]

It is the hallmark of all forms of psychoanalysis to show that a close study of any human action will lead to a knowledge of its causes and purposes that can eventually be understood in the present moment, often in terms of emotional themes from the past. I agree with Strenger that psychoanalysis is committed to the idea that human behavior is "intentional action all the way down," and that, by correctly understanding the meanings of our thoughts and actions, "we help the patient take full responsibility for who he is, and give him the freedom to change if he truly wants to" (1991, p. 63).

Accurate insight into the causes, purposes, and consequences of our suffering opens the door to freedom through the knowledge of our conflicts, deficits, complexes, and other unknown or split-off parts of ourselves. This insight, when it is refined, is not a catalogue or list of damages and misattunements, traumas, and abuses, but rather is a method of examining our moment-to-moment subjective experience. It is a method for studying our subjective responses: when we feel ourselves emotionally triggered, where is this felt in the body—what images accompany it and what thoughts emerge, what are the themes, and so on?

As the analyst (in the role of participating observer), I may be the first to have useful words for what I perceive to be taking place, as I examine my own thoughts, images, and feelings, but this primacy

changes over the course of a treatment as the patient typically finds words and other expressions more available in shaping insights. Some patients are so deeply despairing, or very confused, about their own ability to transform their suffering that they need much more than well-timed interpretations and accurate empathic attunement. They seem to need the hope that comes with a broader understanding of human suffering and its transformation.

For instance, a man in his early fifties entered a three-times-per-week, on-the-couch analysis with me after almost thirty-five years with several different, mostly Freudian, analysts, in mostly on-the-couch analyses. Three and a half years into the analysis with me, he feels a terrible despair because he now sees with some regularity what is going on in his subjective life. His emotional habits have kept him locked into a deadened interpersonal life at home with his wife and children, and into various perverse sexual obsessions and enactments with strangers. He has had a very successful career, and has paid a lot of money to enlist the help of some of the "best analysts" in every city in which he has lived, and he counts me as one of those.

What can be gained from insight into habit patterns when this inevitably leads to still more shame? he wonders aloud. He believes that real insight would mean that he would have to separate from his wife of many years (who is the mother of his children and who was pregnant with the first one at the time of their marriage). This would be an unbearable change, he believes, although he rarely voices this feeling. The patient was placed for adoption as an infant; this event has mixed in his mind with a story he tells himself about his being fundamentally flawed and set apart from humanity. He assumes that his biological parents were young and irresponsible and did not want him. "Leaving his children" (although they are teenagers), the major ingredient in his definition of a divorce, would repeat the terrible trauma that he himself suffered, he believes.

This patient unknowingly invites me silently to dismiss him (as I tend to think his earlier analysts have done), if I am to take seriously his belief that he cannot change and will never leave his unhappy marriage. In this case, I feel that *I* am in a double bind:

should I call a halt to this "interminable" analysis and recognize that his life is "as good as it gets," endorsing his alienation? Or should I continue with the idea that he can change and that he could leave his marriage if he so decided, and bear the brunt of the responsibility for his "leaving his children"? Either way, I would seem to increase his suffering: unhappy in his marriage and unhappy with his perversions, he uses both to affirm his conviction that he is inferior to anyone who has grown up with biological parents (and he assumes that most everyone has, including me).

On countless occasions in our sessions, I have put into words the above insight about feeling caught in a double bind. I am also certain, and have said so, that I must feel as he did as a child: damned to feel alone and alienated when he did not express his feelings with and about his adoptive parents (who were not cruel, but were emotionally unavailable and narcissistic), or damned to feel bad and mean for expressing these feelings. No choice for him, then, but to find ways to control his unhappiness, to feel omnipotent in doing so, to have a hidden sexual perversion in which he is harshly punished and cruelly dominated by a severe woman who is like his adoptive German mother.

With this particular patient, I have found it helpful to take a few steps back from clarifying and interpreting all of this. When I look at the process by which we become trapped in certain meanings (both as analysts and patients), I do not feel so tempted to either call it quits or become cynical about "taking his money," as though I were the dominatrix he had hired. Warmth and humor and openness to new discoveries, in the face of old rigidities, have all helped. Sometimes I recall certain stories that reflect our dilemma, like the following well-known Taoist tale of the farmer. Although I rarely share whole stories with patients, I told him this one:

> One day, a farmer lost his horse because it ran off, and his neighbors came to console him, saying, "Too bad, too bad." The farmer responded, "Maybe." The next day, the horse returned, bringing with it seven wild horses. "Oh, how lucky you are!" his neighbors exclaimed. "Maybe," the farmer said. On the following day, when the farmer's son

> tried to ride one of the new horses, he broke his leg badly. "How terrible!" the neighbors said. "Maybe," the farmer replied. The following day, soldiers came to conscript all the young men of the village, but the farmer's son was not taken away to war because of his injury. "How wonderful for you!" the neighbors said, and the farmer said, "Maybe."

The point of this story—the value of being open to uncertainties and to not knowing—is a vital one (see, for example, Young-Eisendrath 1996, pp. 139-157, and Young-Eisendrath 1997, pp. 649-651, for a fuller discussion), especially for this patient and me. He has been stuck in rigidities for so long and has paid so much money to psychoanalysts. Both of us seem stuck in preconceived positions. I have felt trapped in my double bind, and he has felt too afraid to change. And yet, he says he feels closer to me than he has to anyone, having found that I can make sense of his darkest secrets. He also understands his motivations more objectively than ever before. When he says now that he does not think he will ever change because he is too afraid, I often say, "Maybe."

COMPASSION AND TRANSFORMATION

The successful outcome of a psychoanalysis relies on more than insight into emotional habit patterns, or even accurate empathy and emotional holding. Bald insight can increase a patient's self-condemnation, alienation, shame, and despair. When any of us sees the range and blindness of our own emotional habits, we tend to feel hopeless. Bland empathy can seem weak and useless in the face of strong self-conscious emotions, especially shame. Only compassion for oneself, cultivated over time, seems to me to allow the effects of the analysis to ripen into a transcendent function or dialogical space that can be used fairly reliably in everyday life.

It has been my experience that many people finish (and apparently complete) a psychoanalysis or psychodynamic treatment with a heavy dose of ongoing self-condemnation, and/or an inability to use their analytic skills in the face of powerful emotional triggering. It

may be fine to feel, as some well-known analysts do (see, for example, Hunter 1994) that one has been helped in an analysis without knowing exactly how or why. But if one has not increased one's skill in being able to use a method of self-examination and self-reflection in a way that enhances relationships and other engagements of everyday life, then I believe that the analysis has not been effective.

Compassion—meaning literally suffering *with*—for oneself and others transcends interpretations and insights in a way that allows us to embrace and use the knowledge and skills we gain through insight. Moreover, it permits us to feel "only human," encouraging openness and transparency with others, especially those who are close to us, on whom we depend. By compassion, I mean a kind and loving response to the suffering and adversity of oneself or another. Compassion is more than pity, sympathy, or the urge to help. True compassion allows us to respond to difficulty and anguish in a way that is truly helpful and not simply reactive, trivializing, or premature. Compassion, we might say, is a response that keeps us open to the nature of the difficulty at hand, even when the difficulty stirs hatred, rage, impatience, or shame. True compassion allows us to respond to distress (our own or another's) in a way that is helpful, because the compassion contains within it an awareness of the inevitability of human suffering, lessening our need to attack ourselves or others.

In analysis, in my view, there are two reliable means by which compassion is cultivated, although they are rarely described fully. The first is the patient's engagement in, and eventual awareness of, what I regard as a necessary unobjectionable, idealizing transference, one that is crucial to the therapeutic action. My term for this form of transference, drawing on the work of Modell (1991), is *containing–transcendent* transference. Modell named it *dependent–containing* transference, and showed how it underlies the transformative aspect of psychotherapy (pp. 46-52).

As does Modell, I regard this kind of transference as distinct from what he called *iconic–projective transference:* specific transference of conscious or unconscious emotional images and patterns from childhood dynamics and complexes. Nor is the containing–transcen-

dent transference primarily the product of idealization based on envy of the analyst; that would be a part of the iconic–projective transference. Rather, as I will describe momentarily, the containing-transcendent transference is the byproduct of a well-maintained analytic ritual and a good therapeutic alliance.

I prefer the term *transcendent* to *dependent* because this transference is filled with the hope of transcending symptoms, suffering, and other limitations. It also contains the belief that *this particular* analyst can help me, the patient, transcend my suffering. This analyst is knowledgeable or caring or smart or something—enough for me to trust her or him to be more powerful than my symptoms. Such feelings may initially or eventually be accompanied by the belief that the analyst is "wiser" or "more powerful" than other people in the patient's everyday life.

In my view, these feelings arise naturally in, and are enhanced by, the conditions of the analytic ritual or therapeutic setup (see Hoffman 1998, for an expanded discussion of this). By *ritual,* I mean the relative anonymity of the analyst, the ethical standards of practice, the predictability of time–space–fee routines, and the relative lack of retaliatory actions on the part of the analyst against the patient, as well as the general absence of social chatter. This kind of ritual invites and encourages the analyst to be seen as someone "special" or "powerful" by the patient. Hoffman (1998) called this the "mystique" of the analyst, believing it contributes to the therapeutic action of the treatment.

> With regard to the therapeutic action . . . there is something to the simple idea that the analyst is an authority whose regard for the patient matters in a special way . . . that . . . we do not try to analyze away, nor could we, perhaps, even if we did try . . .
>
> Regard for *the analyst* is fostered partly by the fact that the patient knows so much *less* about him or her than the analyst knows about the patient . . . . The analyst is in a relatively protected position . . . that is likely to promote the most tolerant, understanding, and generous aspects of his or her personality. [p. 203, italics in original]

If the patient cannot or does not feel that the analyst is powerful or special in these ways, several things may be happening. More common than failures, it seems to me, is a confusion: the analyst refuses (or feels too small for) such an unreasonable transference because he or she thinks it is about him or her *personally,* rather than about the transformative process or environment.

This kind of transference may be diminished or compromised over the course of treatment by the analyst's chronic failures of attunement, empathy, or understanding of the patient. In a successful treatment, the containing–transcendent transference will strengthen as the iconic–projective transferences are analyzed and dissolved. In other words, as the patient becomes more skilled, appreciative, and grateful in the transformation of suffering, the patient feels even more impressed with the special qualities of the analyst (not knowing the analyst's personal failings in detail). This happens even as the feeling develops that the analyst is limited, flawed, and human—the outcome of understanding the defensive idealization of the analyst based on envy.

The containing–transcendent transference can also be permanently betrayed and destroyed through ethical violations, gross mismanagement, and/or repeated emotional retaliations against a patient. Even after a treatment has ended—this transference having been strengthened in the course of a successful treatment—the analyst's ethical misconduct betrays the patient's belief, raising doubts and fears about whether treatment gains can be trusted. If this transference is betrayed through serious failures on the analyst's part, the betrayal can forever destroy a patient's hope for renewal, leading to despair about development, or even to suicide in some cases. As Jung wrote of this kind of transference, the patient experiences the analyst as ". . . an indispensable figure absolutely necessary for life. However infantile this dependence may appear to be, it expresses an extremely important demand which, if disappointed, often turns to bitter hatred" (1969, p. 74). Jung went on to say that this transference also expresses a striving for renewal on the part of the patient that, whether conscious or not, should be regarded as extremely important.

What the patient transfers, then, is her or his own potential for ongoing hope and transformation, a potential that can, if the treatment is successful, unfold into compassion for self and others. For some patients (especially those suffering from personality disorders and trauma), the experience of this kind of transference may be the first ever encounter with someone or something that seems to promise the hope for renewal. I believe that this kind of hope constitutes a big portion of the "placebo effect" commonly discussed in research on therapeutic effectiveness.

The second condition for the development of compassion is also related to the analytic ritual: the interdependence of the analyst and patient in the discovery of insight. Over time, the patient and analyst together deeply appreciate the discovery process in which they have engaged—a process enhanced by the constraints of the ritual. They both recognize how they have depended on each other and on the treatment setup, especially in times of tension and pressure. Repeatedly, in the most unlikely moments, when things have been particularly distressing, they have discovered new perspectives or ideas that have transcended their suffering. This has not been simply the imposition of the analyst's interpretations, expertise, or authority; it has been a mutual engagement in a process of investigation of subjective life.

Experiencing this interdependence in the analytic process allows both patient and analyst to appreciate the multiple levels of human suffering and the human dilemma (accountability and responsibility with limited control). The analyst's interpretations of unconscious meanings are put into words and gestures meant to bring insight in such a way that the patient can see how he or she has unnecessarily created suffering. These interpretations are also expanded into narratives about the patient and analyst that reveal over the course of treatment how the patient creates this suffering with the analyst, and what the consequences are. Naturally, the patient feels confused, despairing, or enraged about being accountable for these actions. The effective analyst also sometimes feels confused, despairing, or enraged about being responsible for

the task of transformation, as I discussed above in my own case of the man with perversions.

The analyst's tolerance for her or his own uncertainty, openness to questioning, respect for the interdependent discovery of meaning, and acceptance of blind spots will convey to the patient a compassion for human limitation. This realistic acknowledgment of the limitations of "expert authority" seems to me to play an important role in counterbalancing the forces of the containing–transcendent transference, as well as clarifying that the analyst is unashamed of not knowing. As Hoffman (1998) wrote:

> . . . analytic therapists in general can safely assume that they do not have privileged access to their own motives, nor are they able, despite their advantageous position, to know exactly what is best for their patients. [p. 216]

The limitation of expert authority must, however, be handled in a way that protects the patient's belief that the analyst does indeed "know" that it is possible for the patient to transform her or his suffering (for an example of this working well, see Renik 2000). In other words, the analyst must retain a sense of confidence about analytic methods and the vitality of this specific therapeutic alliance.

In ordinary relationships of everyday life, we are constantly immersed in iconic–projective transferences, as well as in less emotionally charged dynamics, with family, friends, and strangers. The potentials for retaliation, the complications of interpersonal conflict, and various other impingements make it difficult to study the consequences of our complexes, enactments, and fantasies. Within the framework of the analytic ritual, however, with its containing–transcendent transference, we have a unique opportunity to study the transformation of suffering because the context will "nourish some of the analyst's more 'ideal' qualities as a person" (Hoffman 1998, p. 203), while promoting hopefulness and a desire for self-understanding in the patient.

The two kinds of transference present in the analytic situation guarantee a strong affective response—an emotional cooker—

in which the transformation of suffering can be usefully studied as it is ameliorated. Conflicts of dependence–independence, trust–betrayal, and engulfment–abandonment will be necessarily felt in every analytic treatment because they are built into the containing–transcendent transference: the analyst is the repository for the patient's hope for development, and this is uncomfortable for both participants. Conflicts around this hope will be experienced and enacted according to the specific mix of an individual patient with an individual analyst, alongside the iconic–projective themes. In an effective treatment, patients discover that they can depend on and trust the analyst even in times of great despair and challenge. They discover that they will be neither engulfed nor abandoned, not because the analyst always knows what to do or how to think, but because the analyst knows how to work with her or his own emotional dynamics and shortcomings in a way that shows both limitations and a willingness to tolerate uncertainty—depending, again and again, on the process of mutual discovery.

The potent alchemy of containing–transcending and interdependence is repeatedly demonstrated within sessions, along with other analytic and empathic methods for achieving insight into suffering and its creation. It is this alchemy that gradually provides the increase in compassion that in turn allows the patient to leave treatment with an ongoing motivation to use the skills of self-understanding, and allows the analyst to embrace both the patient and him- or herself with feelings of love by the time the treatment is concluded.

KEEPING THE FAITH

Analytic methods of interpretation, inquiry, and empathy are designed to transform individual suffering within the context of a vital, creative relationship: a relationship of discovery. In order to learn how to keep an open mind in the face of unconscious impulses, desires, intentions, and the like, after treatment has ended, a former patient needs to believe that ongoing effort will continue

to lead somewhere worthwhile. Otherwise, the conservative forces of emotional habit patterns will overtake the personality in the absence of a therapeutic relationship.

When people enter into an intensive psychotherapy or psychoanalysis, they have typically already tried many other ways of ameliorating their suffering. With the possible exception of analytic candidates, psychotherapy or psychoanalysis is only moderately desired by the people who pay for it. Analysts also feel ambivalent about their commitment to a process that involves many troubling and chaotic emotional experiences and ongoing exposure to countless narratives of human cruelties and stupidities. Consequently, both patient and analyst are genuinely surprised when they come to feel deeply appreciative and loving toward each other. This "love affair," which in my professional experience often comes about quite strongly just as the treatment is about to end, also undergirds the containing–transcendent transference to one's analyst over the remainder of a lifetime. It seems to allow the patient, as I hear in reports from people who come back for consultations after analysis (and as I know from my own analyses), to continue to draw on a wise and compassionate "therapist within" in moments of special overwhelm and challenge.

All of these lead to a fairly reliable faith in, and motivation to use, the transcendent function or dialogical space to hold open experiential moments of emotional meaning while feeling emotional pressure to react. Ongoing examination of one's own omnipotent longings and desires, as well as one's tendency to project and identify with certain images and dynamics, should continue to lead to modesty about isolated, uncorrected self-analyses, once treatment is over. As noted earlier, appreciation of interdependence strengthens our compassion—our ability to suffer with ourselves and others—and our willingness to be more transparent about our failures and fears.

Of course, a patient has attained some self-knowledge of the personal habit patterns that shape the particular complexes and conflicts of her or his personality. In resolving the iconic–projective transferences with this particular analyst, the patient has ex-

perienced the possibility of transforming old habit patterns in the moment, or soon after, they occur. The patient has encountered shameful and difficult sexual, aggressive, cruel, hateful, and envious feelings and images, and has found that even these were ultimately helpful and useful for understanding the self. In the last stage of a treatment, the patient has also worked collaboratively to apply the skills gained in treatment sessions to the world outside, and has felt the analyst to be a partner in that endeavor. All of these experiences have led to the transformation of suffering into insight, compassion, and renewal.

The transformative effects of a psychoanalytic treatment should live on forever. Even years after the death of one's analyst, news about him or her can have an effect on the treatment. This is a great responsibility for those who take on the role of analyst. It is a responsibility to remain an ethical and committed practitioner and person in order to allow for the containing–transcendent transference to flourish over time. And yet, as I mentioned earlier, it is a serious error for the analyst to believe that this transference is a personal matter. Although the analyst plays an important part in competently handling the constraints of the analytic ritual, this kind of transference arises spontaneously out of the universal hope for the transformation of suffering when that hope can be sustained.

Mistakenly identifying oneself personally with the powers of this transference always leads to destructive errors and actions, of which there are innumerable examples among charismatic psychotherapeutic and psychoanalytic leaders. Such people have usually demanded that others adhere to their particular formulas and ideas—rather than to a process of inquiry and discovery—because they believe that they alone hold unique powers of transformation. Unfortunately, such a therapist or analyst will betray the effectiveness of the containing–transcendent transference, either through disastrous errors or by believing to be beyond criticism.

In my view, a stance of dogmatic certainty or isolated superiority is the reverse of what is demanded for effective transformation of human suffering. The adequate maintenance of the analytic ritual, with its ethical and generally nonretaliatory commitments, al-

lows the analyst to engage openly in a process of discovery, without having to know in advance or even to know at all (in many ways) exactly how to interpret or understand particular enactments, images, and so on. Rather than demonstrating to the patient an attitude of being beyond criticism, the effective analyst will naturally show a willingness to be corrected and guided by the patient, while also remaining confident about how the process or method of transformation works, and how insight and compassion are manifest in human actions.

In conclusion, then, I regard the aim of effective psychoanalytic treatment to be the amelioration of suffering that is revealed through the emotional habit patterns expressed in the iconic–projective transference, dreams, and reports of other relational patterns. This process leads also to an increase in compassion for self and others as the investigation of the patient's suffering takes place. The containing–transcendent transference, the transference of hope for renewal, will be strengthened over the course of effective treatment, rather than resolved. As a result, the patient leaves treatment with not only new skills and perspectives for increasing subjective freedom, but also the motivation and humility to continue to do so. The latter traits develop especially out of ongoing compassion for oneself and others.

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Psychoanalytic Quarterly, LXX, 2001

OVERVIEW AND COMMENTARY

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The decision to devote an issue of *The Psychoanalytic Quarterly* to the goals of clinical psychoanalysis is a timely one. A lack of clarity about goals has undoubtedly damaged the credibility of the whole psychoanalytic enterprise in the eyes of fellow mental health professionals and in the eyes of society in general. As Goldberg notes in his contribution, "As much as we would like it to be otherwise, we are haunted by vagueness" (p. 128). This vagueness takes many forms. Are we speaking of the psychoanalyst's goals or the patient's goals? Are we referring to conscious or unconscious goals? Process or outcome goals? Do we even endorse the notion of goals for a psychoanalytic treatment, or is psychoanalysis essentially goalless? Is there still a valid distinction between psychoanalytic and psychotherapeutic goals, or between treatment goals and life goals?

These dilemmas are not new. They were present at the dawn of psychoanalysis, when Freud struggled with the dialectic between the psychoanalytic approach as a way to help the patient recover from an illness, and psychoanalysis as a research tool to investigate the human mind. In 1904, he clarified: "The task consists of making the unconscious accessible to consciousness, which is done by overcoming the resistances" (p. 253). He then went on to say, "The aim of treatment will never be anything else but the *practical* recovery of the patient, the restoration of his ability to lead an active life and in his capacity for enjoyment" (p. 253, italics in original). In addition, of course, the tension between an optimistic view of what analysis might achieve and a more pessimistic one of its limitations is a ubiquitous thread running throughout Freud's writings (Sandler and Dreher 1996).

What may be different today is a sense of urgency about defining the fundamental goals of psychoanalysis. The historical tendency of analysis to eschew issues of effectiveness and outcome has marginalized it as a treatment within the mental health professions (Gunderson and Gabbard 1999). A smorgasbord of treatments are now available to the consumer of mental health services. Freud is declared irrelevant or fraudulent at regular intervals in the media, and we hear in the age of Prozac that breakthroughs in the understanding of neurotransmitters have sounded the death knell for psychoanalytic treatment. As Widlöcher emphasizes in his article, the treatment targets of the psychopharmacologist and the psychoanalyst have little in common, and when we create a horse race between medications and psychoanalysis, we have fallen into a counterproductive exercise of comparing kumquats and artichokes.

Yet we had better have some idea about which outcomes are unique to analysis if we are to retain credibility. In this issue, Greenberg states succinctly:

> . . . if our goals are the same as those of other treatment modalities, we are at pains to demonstrate why anybody should undertake analysis rather than some other therapy that takes less time, requires less effort, and is vastly less expensive. [p. 133]

A formidable resistance within the analytic profession stems from the skepticism with which it regards outcome goals. But the privileging of analytic process over therapeutic results has crippled our efforts to define our uniqueness. Those who argue for measurement of outcomes are often accused of countertransferential ambition to heal that warrants a return to the couch for further analysis. Constructivist and postmodern trends in recent analytic discourse have led to a retreat from the systematic assessment of how particular technical strategies or theoretical perspectives might be more or less effective with particular patients (Bader 1998). *The Psychoanalytic Quarterly*'s editor, Owen Renik (1998), has pointed out that if analytic treatment is not geared to help the patient, we may end up analyzing a greatly reduced population—namely, ourselves.

Renik has assembled an international group of distinguished contributors for this Special Issue. The reader is exposed to a series of well-argued statements about the contemporary status of analytic goals, covering a range of theoretical perspectives and representative of the pluralistic era in which we practice. Nevertheless, the reader will note that several contributors seem to focus more on theories of therapeutic action and technique than on a systematic discussion of goals. This digression is entirely understandable because any consideration of where treatment is headed will inevitably lead to a discussion of how to get there. Goals are to therapeutic action as the destination of a journey is to the vehicle designed to take us there. For some destinations, an automobile will suffice, while for others, a plane, train, or ship may be necessary. The analytic journey today has a multiplicity of destinations, depending on the theoretical perspective of the analyst, further complicating any effort to identify overarching goals of treatment. Bernardi points out in his article that we cannot even agree upon what constitutes evidence so that we might be able to conduct a useful discussion about the advantages of different models. Widlöcher appears to concur, stressing that theory inevitably affects which data are examined and which are ignored.

Some matters have become clearer with time. Abend, in his article, observes that "no analyst today would suggest that the acquisition of insight is all that transpires in a successful analysis, or even that it identifies the sole therapeutic influence of the analytic experience" (p. 5). Indeed, a patient who acquires insight without accompanying change in functioning would serve as a poor poster child for a marketing campaign promoting analysis. Jacobs, in his contribution, poignantly describes his frustration with patients who receive apparently accurate interpretations, but remain frozen in neurotic inhibitions or anxieties. He traces our less than admirable history of emphasizing how the mind works as our principal goal, even though our patients have seldom agreed.

This set of articles reflects a growing reluctance among analysts to draw a sharp distinction between therapeutic and analytic goals. Berman comments on the historical problem of idealizing

structural change, while treating symptomatic or clinical change with suspicion and even contempt. Bernardi emphasizes how little we appear to value symptomatic change, even though, from the patient's perspective, relief of suffering may be the primary motivation for seeking analytic help. In an unusually clear exposition of Lacan's view of goals, Patsalides and Patsalides underscore Lacan's skepticism about the value of understanding. And Renik states outright:

> For me, *the test of the validity of any understanding arrived at in clinical analysis is whether it yields therapeutic benefit.* No matter how compellingly a formulation accounts for the patient's experience, past and present, within and without the treatment relationship, and no matter how much conviction develops about that formulation on the part of analyst and patient, if the understanding is not accompanied by desired life changes for the patient, its validity is suspect, in my opinion. [p. 236, italics in original]

On the whole, the authors in this issue would appear to be dissatisfied with changes limited to understanding. Improvements in functioning, relief of distress, and other symptomatic changes are now viewed as essential components of a good analytic outcome. Wallerstein's (2000) monumental follow-up of the Menninger Psychotherapy Research Project patients stressed that the evaluation of therapeutic change versus analytic change is virtually impossible.

Only Caper, alone among the contributors in this issue, expresses strong skepticism about therapeutic ambitions. The goal of analysis, in his view, is "to improve the patient's capacity to be in contact with and to tolerate his or her mind as it is, so that the patient may develop independently" (p. 110). Interpretation is the royal road to this goal, and attempts to "cure" run the risk of imposing the analyst's preconceptions on the patient. Yet Caper's emphasis on psychological growth and development suggests that relief of suffering and similar therapeutic outcomes might well result from analytic work, and that insight without psychological growth would be suspect. Kennedy (1998) has noted a paradox in our field:

> It may be inadvisable for an analyst to hope too much that his patients get better, but if none of them do, then I personally find it difficult to imagine why on earth he would be working as an analyst. [p. 118]

Another impression the reader takes away from this collection of articles is that Ticho's (1972) classic distinction between treatment goals and life goals may be losing its usefulness. Bernardi questions how sharply the line of demarcation can be drawn between these two constructs, given that clinical symptomatic change has such profound influences on the way that one lives one's life. Analysis, in Renik's view, is a treatment that specifically seeks to assist the patient in bringing about desired life changes. How many analysts would be satisfied with a patient who gained an understanding of the psychological obstacles that prevented him or her from achieving intimacy in relationships, but who continued to live a life of isolation? Abend stresses that analytic goals are to help the patient acquire the psychological tools to pursue life goals. If the tools are acquired but not used, wouldn't many view it as a cop-out to say that the analyst's responsibility ended with the patient's acquisition of tools? Jacobs provides richly evocative clinical material to illustrate that analysis has failed if positive life changes do not result.

Of all the authors in this issue, only Bergmann appears to make a major point of the difference between treatment goals and life goals. In his view, analysts can be faulted for *not* leaving life goals to their patients. The essence of being an analyst is to maintain "a double stance—giving the analysand maximal free space to pursue his or her own life goals, and at the same time, keeping control over the changing goals of the analytic process itself" (p. 32).

The conflict between the analyst's goals and the patient's goals is acknowledged by most of the contributors herein. Berman emphasizes that such a conflict is inherent, and that it requires resolution via a negotiation process between analyst and patient. Writing from an intersubjective perspective, he notes the complexity of countertransference, and suggests that "any expression of the analyst's goals

must be taken with a grain of salt" (p. 41). Bernardi, on the other hand, feels that making the analyst's goals explicit to the patient can be useful. He also stresses that one should not equate the fact that the patient is satisfied with the results of analysis with the achievement of good results. Renik stresses that when conflicts arise between analyst and patient regarding progress toward goals, the patient has the last word, because the analyst is not in a privileged position to say whether the primary goals of the treatment have been achieved. Although Renik allows for the possibility that the patient's achievement of goals may be illusory or defensive, he does not clarify how the analyst can best differentiate legitimate therapeutic benefit from defensive flights into health. Like Bernardi, however, Renik feels that explicit discussion of the analyst's goals with the patient is an essential feature of the process, one that should be taken seriously.

Few of this issue's authors would endorse the attachment theory perspective advocated by Holmes (1998), who argued in favor of aimlessness. Holmes suggested that the aim of analytic treatment is to provide an environment that fosters attunement, and that what will happen in any given analysis cannot be prescribed in advance. In this issue, Mitchell argues for the value of substantial periods of analytic work in which there is a "no-search" approach that allows a certain degree of aimlessness. Echoing a point made by Caper, he stresses that an unrelenting pursuit of goals can become persecutory for the patient, and may lead to a "false-self" compliance. I share Mitchell's concern and have stressed in my own writing (Gabbard 2000) that the analyst who is too concerned about achievement of goals may paradoxically promote a transference-countertransference enactment in which the patient defeats the analyst's efforts, thereby winning by losing. On the other hand, I also share the view of several of the contributors, including Berman, Renik, and Bernardi, that extremely long analyses that appear to be meandering endlessly should be a cause for concern in all of us who value analytic work. Optimally, there is always some balance between the pursuit of goals and the allowance for goallessness, a balance that is ultimately negotiated between analyst and patient.

What is missing from this fine collection of essays, in my view, is a systematic examination of how specific patient characteristics influence the endorsement of aimlessness versus the pursuit of specific therapeutic goals. In other words, *for whom* is goallessness preferable, and in which clinical situations? For certain patients who are riddled with envy and incapable of acknowledging help from the analyst, an insistence on goals is self-defeating because changes may occur only *after* termination, when the analyst is not around to witness them. For other patients, clearly articulated goals serve as an orienting beacon as they flounder in a sea of darkness.

Even when we take individual patient factors into account, however, we must still face the question of whether there is some fundamentally unique goal for analysis that places it apart from other treatments and justifies its time and expense. Goldberg asserts in his contribution that we really need to think in terms of multiple goals, and he identifies a threefold set: self-understanding, relief of discomfort, and lasting permanent change. He also compellingly argues for the need to tailor goals individually to each patient. Blatt's empirical research (1992) supported this notion through an initial attempt to identify how both goals and therapeutic action vary, depending on patient characteristics. In his reanalysis of the Menninger Psychotherapy Research Project data, he described one group of patients as introjective, in that they were preoccupied with establishing and maintaining a viable self-concept rather than establishing intimacy in the interpersonal realm. Their defenses revolved around intellectualization, rationalization, reaction formation, doing and undoing, and projection. Insight and interpretation appeared to be more important in the work of this group. Anaclitic patients, on the other hand, were more concerned with issues of relatedness than with self-development, and tended to use avoidant defenses, such as disavowal, withdrawal, denial, repression, and displacement. These patients appeared to gain greater therapeutic value from the quality of the therapeutic relationship because that was more in accord with their goals.

Several contributors to this issue, including Berman, Widlöcher, and Abend, cite some variation on freedom of choice or freedom of

thought as a major goal of psychoanalysis. Although freedom is almost always relative, certainly most analysts would endorse this goal in one form or another. Enslavement is often preferable to freedom in the lives of distressed patients, and only treatment of substantial length may be effective in removing the shackles to which so many patients have become intensely attached.

In my own view, we analysts are a bit disingenuous when we say that we are not interested in symptomatic changes in the same way that are those who practice cognitive therapy, interpersonal therapy, or pharmacotherapy. Of course we want to help our patients with distressing symptoms. In designing follow-up studies of analytic treatments, we should include standard symptomatic outcome measures to illustrate that analysis does indeed result in symptomatic improvement. In this regard, one of the impressive findings of the Stockholm Outcome of Psychoanalysis and Psychotherapy Project was that the symptom distress variable was the most responsive of all variables to analytic treatments (Sandell et. al 2000). We must be mindful of Friedman's (1988) caveat that we should not assume that "our patients share our commitment to advancing the goals of analysis as a profession that go beyond the relief of symptoms and the recovery of inner freedom" (p. 36).

In addition to symptomatic relief and the freeing up of one's inner world, the analysts contributing to this issue are interested, like the rest of us, in defining that "something more" that motivates our patients to seek analytic treatment and that compels us to pursue a career in psychoanalysis. Grinberg (1980) suggested that analysis is geared to finding the truth about oneself. Similarly, in this issue, Young-Eisendrath suggests that a goal of analysis is for the patient to "leave treatment with an ongoing motivation to use the skills of self-understanding" (p. 281). Steiner (1989) expressed the belief that we strive to reintegrate aspects of the self that had been previously lost through projective identification. This goal is closely related to what I have described elsewhere as "helping patients learn to live within their own skin" (Gabbard 1996, p. 231).

Greenberg argues that analysis promotes a specific ethos: that we become our best through self-reflection. In this regard, Green-

berg suggests that the "something more" we derive from analysis has an ethical and even aesthetic dimension. Inherent in Greenberg's view is that analysis pushes understanding to its limits. The analyst does not stop with one determinant. In psychoanalysis, we eschew reductionism. We look for a myriad of determinants, knowing that the full, multilayered texture of any symptom, fantasy, or behavior may elude us. As Bottom said in Shakespeare's *A Midsummer Night's Dream,* "…it shall be called Bottom's Dream, because it hath no bottom" (Wright 1948). Indeed, there are many times that we do not get to the bottom of things (so to speak) in our analytic efforts, but we are dedicated to the most far-reaching understanding that we can obtain. Greenberg notes that self-reflection includes the recognition that there are limits to understanding. I agree, and I add that tolerance of not knowing all we would like to know about ourselves is instrumental to becoming our best, as Greenberg puts it. Perfectionism is antithetical to living within one's own skin, and we must be able to settle for the limits of knowledge in our analytic work. Likewise, we must have compassion, both for our patients and for ourselves, as Young-Eisendrath emphasizes in her contribution.

How we reach our goals in clinical psychoanalysis with any given patient is a highly idiosyncratic and individualized undertaking. Samuel Butler once said that life is like playing a violin in public and learning the instrument as one goes along, and the same could be said of every psychoanalysis.

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