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EDITOR'S INTRODUCTION

Theory and Practice: Intimate Partnership or False Connection?

BY HENRY F. SMITH, M.D.

Eugen Bleuler (1912), the Swiss psychiatrist who gave schizophrenia its name, once said of schizophrenic thought that "it thinks" in the patient (p. 23, quoted in Forrest 1965). So, too, does psychoanalytic theory "think" in the analyst.

Freud (1915) put it about as well as one can in discussing the origin of scientific theory. "Even at the stage of description," he wrote, "it is not possible to avoid applying certain abstract ideas to the material in hand, ideas derived from somewhere or other but certainly not from the new observations alone." He continued, "We come to an understanding of [the] meaning [of these ideas] by making repeated references to the material of observation from which they appear to have been derived, but upon which, in fact, they have been imposed" (p. 117, quoted in Smith 1992, 1999).

Nor is the patient immune from his or her own personal indwelling theory. As Cooper (1985) has said, "Without a theory we are unable to select data from the massive jumble of impressions that constantly assail us. Neither psychoanalysts nor naive psychologists—the man in the street—are able to function without a theory" (p. 5). And Friedman (1988) puts it bluntly: "We cannot think without theory" (p. 7).

A key player in the discourse on the relationship between theory and practice, Friedman has devoted much of his work to the elucidation of how theory "sits (or hides) in the therapist's

mind" (p. 9), where it illuminates opportunities, reassures the therapist that there is something to grasp, indicates how to grasp it, and steadies the therapist with a "cognitive brace" (p. 76), as it privileges and disciplines the therapist's listening. In Friedman's view, theory soothes the therapist's inevitable and multiple discomforts, and particular theories or part-theories have evolved to address those discomforts in particular ways.

Friedman makes the presence of theory so immediate that we might at times be beguiled into thinking we need not distinguish one form of theory from another, as if we do not need to ask, Theory of what? Mind? Technique? What levels of theory are we talking about? Do they all have a function in clinical work?

LEVELS OF THEORY

Perhaps the clearest description of the different levels of psychoanalytic theory was Waelder's (1962) summary of a symposium on scientific method. Taking his cue from a presentation at the symposium by Hartmann (1959), who had commented on the levels of abstraction in psychoanalytic theorizing, Waelder wrote:

> In speaking of psychoanalysis or Freudian doctrine, one can distinguish between different parts which have different degrees of relevance. First, there are the data of observation. The psychoanalyst learns many facts about his patient which other people, as a rule, will not get to know. Among them are facts of conscious life which people are not eager to relate to others, not even to psychological interviewers, or about which they do not care to tell the truth, or the whole truth, or of which they do not usually think but which will occur to them and which they will relate in the psychoanalytic interview because of its peculiar climate mixed of relaxation and discipline, of intimacy and personal aloofness. To this, one must add the things which are not conscious or preconscious but can send derivatives into consciousness under the conditions of the psychoanalytic situation. The psychoanalyst learns not only about all such data but also about the configurations

in which they appear. All these form what may be called the *level of observation*.

These data are then made the subject of interpretation regarding their interconnections and their relationships with other behavior or conscious content. This is the *level of clinical interpretation*.

From groups of data and their interpretations, generalizations have been made, leading to statements regarding a particular type such as, e.g., a sex, an age group, a psychopathological symptom, a mental or emotional disease, a character type, the impact of a particular family constellation, or of any particular experience, and the like. This is the *level of clinical generalizations*.

The clinical interpretations permit the formulation of certain theoretical concepts which are either implicit in the interpretations or to which the interpretations may lead, such as repression, defense, return of the repressed, regression, etc. This is the *level of clinical theory*.

Beyond the clinical concepts there is, without sharp boundaries, a more abstract kind of concept such as cathexis, psychic energy, Eros, death instinct. Here we reach the *level of metapsychology*.

Finally, Freud, like other thinkers, had his own philosophy, his way of looking at the world, and he was more articulate than many in expressing it. His philosophy was, in the main, the philosophy of positivism, and a faith in the possibility of human betterment through Reason—a faith which in his later life, in consequence of his psychoanalytic experience, became greatly qualified though not altogether abandoned. This may be called the *level of Freud's philosophy*.

These levels are not of equal importance for psychoanalysis. The first two, the data of observation and the clinical interpretations, are entirely indispensable, not only for the practice of psychoanalysis but for any degree of understanding of it. Clinical generalizations follow at close range. Clinical theory is necessary too, though perhaps not in the same degree. A person may understand a situation, symptom, or dream with little knowledge of clinical theory, and while this would certainly not be enough

> for a practicing analyst, one would yet have to recognize that such a person has a considerable measure of understanding of psychoanalysis.
>
> Metapsychology, however, is far less necessary, and some of the best analysts I have known knew next to nothing about it. These are the kinds of hypotheses about which Freud (1914) said that they are "not the bottom but the top of the whole structure [of science], and they can be replaced and discarded without damaging it" (p. 77).
>
> Freud's philosophy is largely a matter of his time and has little bearing on psychoanalysis. [Waelder 1962, pp. 619-620, italics in original]

Given how much play the role of philosophy has had in recent debates about both theory and practice, Waelder's last comment is at odds with much of contemporary rhetoric, as I shall discuss below.

Clear as Waelder's levels of theory are, his notion that some levels are closer to the data than others, or less relevant than others, has come under sharp criticism. Brenner (1980), for example, has disputed the idea that higher levels of abstraction lie further from the data of observation. Echoing Freud's comment above, he writes, "In every branch of science even the simplest observations involve ideas of the highest order of abstraction," adding "what makes a theory useful" is not the level of abstraction but "the degree to which a given theory is supported by the relevant data" (p. 200). Even if Waelder simplifies the mix of theoretical levels with which we work clinically, as a descriptive exercise, his hierarchy remains, in my view, a useful tool for analyzing the way levels of theory become muddled in our discourse (Slap and Levine 1978; Smith 1997). Further, even though the data of observation are shaped by theory to an extent Waelder did not take into account, his levels of abstraction appear to be descriptively accurate across a wide range of psychoanalytic schools of thought.

Friedman's inclusion of all levels of theory in his considerations of practice becomes clearer in the light of Brenner's comment above. As Friedman (1988) himself puts it, "A 'clinical theo-

ry' purified of metapsychology is probably a self-contradiction" (p. 86). I would conclude, therefore, that in one sense, the distinction between a theory of mind and a theory of technique is an artificial one. *All theory that derives from and participates in the clinical situation is ultimately clinical theory, and all efforts to organize our observations, experience, and interventions in the analytic situation can be considered exercises in the use of theory.*

WHERE IN THE MIND DOES THEORY SIT?

If indeed theory "thinks" in the analyst, as Freud, Waelder, Brenner, and Friedman all testify, each in his own way, it would seem essential for us to know not only what our theory is thinking, but also how and where it thinks. While all analysts must seek help from their theories more deliberately and explicitly at some moments than at others, for some analysts, theory seems to regularly inhabit the front of the mind, whereas for others, it sits somewhere to the rear or to the side, a presence but a less insistent one.

Bearing in mind that when analysts write about their work, there is a complex relationship between their writing and their analyzing, when some analysts write about their work, we think we see clearly and cleanly the operation of their theory. Gray (1986), for example, gives us detailed clinical observations that demonstrate his use of structural theory as a kind of optical filter through which he can observe moments of conflictual interference on the surface of the patient's mind. Although they share a common commitment to the structural model, in Gardner's (1983) clinical descriptions, theory itself is more elusive. Gardner (1995) writes, "I prefer a theory that guides my attention, but does so gently. I prefer a theory that's simple enough to remember and complex enough to 'forget'" (p. 90). If Gray's approach appears to be theory-near, Gardner's might be said to be theory-distant—or near at some moments and distant at others. Similarly, whereas Gray (1982) suggests that technique lags developmentally behind theory, Gardner, while agreeing, nevertheless counters that "some aspects

of theory lag behind practice," adding "art, in the main, goes far ahead of theory and it's theory's job to try persistently to close the gap" (1995, p. 79).

For purposes of discussion, I want to make it clear that by *theory-near* and *theory-distant*, I am trying to suggest a number of variables in analyzing. First, how deliberately and consciously does an analyst use his or her theory, how near to awareness is it at any given moment? Second, how closely integrated with that theory are the observations the analyst makes? These two characteristics may coexist but are not synonymous. And finally, how fluidly does an analyst move between a more conscious and less conscious grip on his or her theory, or within any one preferred mode of analyzing? These variations in the *use* of theory are largely independent of the wide range of phenomena analysts may preferentially select for observation.

Along with these reflections on the location of theory, consider Sandler's (1983) observation that while we all have a preferred, or what he calls a "public" theory, we maintain various preconscious, private theories that live in quite harmonious contradiction with our public or primary theory, as long as we do not bring them into the light of day. I would note that we all make observations that do not fit easily with our preferred theories. If we can catch them, such observations represent opportunities for a creative advancement in understanding, as long as we resist the temptation to enshrine them prematurely with new theoretical explanations. Given our natural and essential inclination to generalize from our observations, this is more easily said than done.

THE MISUSE OF THEORY

If the relationship between theory and practice is always an intimate one, with theory both derived from and imposed on observation, as Freud indicated, it would appear that what we observe in practice are clinical units in which theory and observation, while occupying distinct conceptual levels in Waelder's terms, are

thoroughly interwoven. It also seems clear that every theoretical commitment tends to push our habits of practice in one direction or another.

As I have indicated (Smith 1997, 1999, 2001), however, in the contemporary literature it has become commonplace for writers, deliberately or inadvertently, to represent theory and practice as much more tightly linked than is warranted in an effort to make their practices seem more lawful than they are. Under such circumstances, rather than theory and practice cooperating as intertwined but separate entities, the two are in fact conflated, and the intimate partnership between them becomes a false and misleading one.

Thus, we find analysts obeying a clinical theory, derived from the observations of practice, as if the practice were now "owned" by the theory, which, in turn, tells them what to do. Others deliberately buttress a new or preferred technique with a new theory of mind—or even of brain (Smith 1997)—or justify their interventions according to their own philosophical or epistemological assumptions. We hear analysts retrospectively explaining their use of self-disclosure, for example, on the grounds that it is consistent with their intersubjective principles, rather than because it is clinically indicated with a particular patient. Note that in any of these examples, not only do the distinctions Waelder drew between one level of abstraction and another collapse on themselves, but the sequence that he described from observation to theory is inverted.

I want to emphasize that in my illustration, I am not taking a stand for or against either self-disclosure or intersubjectivity. Rather, I would suggest that the form of argument linking theory and technique in such a fashion ignores the fact that many aspects of practice—including what we reveal about ourselves, deliberately or not, along with our tone of voice, gestures, affective engagement, and authenticity, not to mention the level of uncertainty we tolerate and our capacity to question our own assumptions—-are not the province of any one theoretical position or school of analysis. Similarly, many variations in practice can

flourish under the banner of a single theory. Conceptually, theory and practice exist in different domains, at different levels of abstraction, and are far more loosely coupled than these false connections imply.

In his important contribution to this issue of the *Psychoanalytic Quarterly*, Fonagy (2003) elaborates on several of these points from a somewhat different perspective. He argues that analytic practice developed historically by trial and error, and that analytic theory grew out of analytic practice. In that respect, it was, at least in part, an inductive process, from observation to generalization. But subsequently, Fonagy suggests, we have all tried to use theory deductively, as if it could tell us what we are seeing and what to do. It is this latter use of theory as a directive for practice that concerns me here.

I would suggest that the format of much of our literature confirms and recapitulates the very sequence Fonagy is outlining. A writer begins with a review of the literature, followed by a clinical vignette, and then a theoretical comment that seems to derive from the clinical material. This is then accompanied, not infrequently, by another vignette, and soon the clinical material seems to follow from the theory, rather than the other way around. In some cases, this appears to be a rhetorical device to grant authority to the practice in question; in others, it seems a deliberate attempt to ground both observation and technique in a general theory. Even with no such conscious motivation on the part of the writer, but simply as a byproduct of the narrative sequence, the effect tends to be the same on the reader: both theory and practice *feel* more persuasive because of their mutual reinforcement. Sometimes we observe this sequence in a single article; at other times we see it unfold over a series of articles or in the work of multiple authors, as schools of analysis evolve and become established.

It is not difficult to see how these trends might take root even without artful intent. When patients oblige us by getting better under our care, we take this as confirmation not only of our practices, but also of the theories we have evolved to

explain them. Moreover, as readers, we seek such reassurances. That is one of the reasons we read. The point is that sooner or later, theory begins to function as law, and practice follows behind.

One can see the effect of these false connections not just in the use of theory as a technical directive, or in the deliberate building of new theory, but also in the doubts that begin to gather around the old. As I indicate elsewhere in this issue (Smith 2003, pp. 80-89), a master clinician like Philip Bromberg, for example, anchors his clinical insight and technical agility to a theory of mind based on dissociation. It is the dissociative mind that underwrites, and hence "necessitates," his attention to the multiple states of the patient. This is a radically different view of the mind than the one on which many analysts were raised. It may in fact be correct, but I have heard clinicians argue that in order to be flexibly attuned in the clinical hour, as Bromberg is, or to adopt the practices of any number of other compelling contemporary writers, they must discard the old concepts they learned, including the view of a mind in conflict. In other words, to adopt the practice, they have to adopt the theory with which it has been packaged, an assumption that I would suggest is no more warranted than that the two needed to be so tightly linked in the first place.

We might note in passing that it is not uncommon in psychoanalytic education to see courses on comparative psychoanalysis taught along the lines of just such a one-theory/one-practice model, with no disclaimer offered on the limits of theory and its role in practice. What results is a kind of idealization of theory that may be particularly problematic in those programs with a specific theoretical agenda. In my experience, such idealizations, if unchecked, may leave students feeling demoralized by their own uncertainties, grasping at one theory or another to guide them in the heat of the clinical moment, and foreclosing the development of their own clinical voice with premature theoretical commitments.

I am not singling out anyone as responsible for these false connections between theory and practice. We all inevitably try

to use theory to simplify our work, rather than to reveal its complexities, and we find solace in the general rule as a protection from the exigencies of the particular situation. Moreover, we all try to give our preferred techniques a theoretical legitimacy they cannot claim, rather than depending on clinical evidence to prove their efficacy. We do this because we do not know what else to do. But as a result, over time, our literature comes to resemble a kind of patchwork quilt of theory and practice, in which each appears to support the other with scarcely any evidential connection, and almost every apparently useful intervention can be explained after the fact by a wide variety of contemporary theories.

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This special issue of the *Quarterly* was conceived by Sander Abend, who, together with Owen Renik, chose the contributions and did much of the editorial work before I became the *Quarterly's* Editor. I am very grateful to them both.

You will note that, while all the papers explore different aspects of how theory affects practice, some of them lean more toward theory and others more toward practice. In the former group, in addition to Fonagy's exploration of the scientific status of psychoanalytic theory, Reed assumes the nearly impossible task of trying to observe how theory functions in her mind as she analyzes, Rey de Castro illustrates his experience of "free-floating theory" in the clinical hour, as he explores our inability to pin down clinical theory in the first place, and I differentiate several contemporary views of conflict and their influences on clinical technique. The other authors, Aisenstein, Blevis and Feher-Gurewich, Busch, Ferro, Hirsch, and the Ornsteins, have all contributed generous samples of their own clinical work to illustrate the function and effect of their own preferred theories. The issue concludes with Michels's typically masterful discussion.

Rather than settling any of the many questions that lie before us, we hope with this project to unsettle some of your own theo-

retical predispositions, both as to the content of your theories and to your use of them in practice. You will note that we have included a range of psychoanalytic approaches in this volume, some of which you may find frankly unsettling in themselves. It is my belief that only as we develop a capacity to study the work of others more dispassionately can we begin to determine what separates "us" from "them," and what might lead toward a degree of reconciliation. It is also my belief that if we were each to report what we observe ourselves doing in a form as close as possible to the way we both observe and do it, we might challenge familiar theoretical affiliations, and in so doing, discover a few strange new bedfellows. We might even put to rest some of our seemingly endless, and most assuredly fruitless, political battles.

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SOME COMPLEXITIES IN THE RELATIONSHIP OF PSYCHOANALYTIC THEORY TO TECHNIQUE

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This paper considers the current fragmentation of psychoanalytic theory as a result of the illusorily close association of practice and theory. The author argues that the politically motivated assertion of a direct connection between theory and practice should be set aside and that practice should be liberated from theory, permitting theory to evolve in the context of radically modified patterns of practice. If theory were decoupled from practice, technique might progress on purely pragmatic grounds, on the basis of what is seen to work. Psychoanalytic theory of mental function could then follow practice, integrating what is newly discovered through innovative methods of clinical work. Such a pragmatic, principally action-oriented use of theory would bring psychoanalysis more in line with modern, postempirical views of science.

INTRODUCTION

We have become quite accustomed to worrying about the future of psychoanalysis. Mostly, when gripped by anxiety about the future of our discipline, we tend to focus on the lack of psychoanalytic patients, the lack of appropriate candidates, the persistent and increasingly well-received critiques of psychoanalytic theory and practice, the strengthening of alternative therapeutic approaches (particularly biological psychiatry and cognitive behavior therapy),

and, even more worrying to some, the spawning of loosely psychoanalytically oriented, psychotherapeutic approaches, often masquerading as psychoanalysis, which insidiously invade our practice. But what I would like to focus on is far worse than any of these. My concern is the knowledge base of psychoanalysis.

Over recent decades, psychoanalytic theory has become increasingly fragmented. The decline in citations of recent analytic articles in all journals, including psychoanalytic ones, provides evidence of this (Fonagy 1996). Preliminary explorations suggest that not only are contributors to the social science and medical literature increasingly disinterested in analytic journal publications, but also analysts themselves are apparently less interested in the ideas of other, currently active, analytic groups. Arguably, the major analytic schools that emerged following Freud's death, and that organized the discipline over the latter half of the twentieth century, are breaking apart in the twenty-first. Ego psychologists are hard to find, Winnicottians are no longer just Winnicottian, self psychologists have fragmented, Kleinian-Bionians have less and less in common with each other beyond these two giants of the field, Anna Freudians were arguably an improbable grouping even during her lifetime, and the interpersonalist approach has become the home of refugees and asylum seekers from all the above traditions.

This fragmentation, euphemistically characterized in the literature as pluralism, could potentially be fatal to psychoanalysis. If present trends toward theoretical schism continue, and analytic writers come to share only history and terminology, the discipline ultimately faces theoretical entropy, with all writers jealously protecting their ever-diminishing psychoanalytic patch. As the possibility of consensus recedes further and further, it will become increasingly difficult to claim a general application for any particular theory, and thus even the theoretical potential of analytic theories interfacing with clinical practice could disappear.

This paper aims to make a contribution to halting or even reversing this process by offering an analysis of how the current fragmentation of theory might have come about through the appar-

ently close association of practice and theory. I will argue that the fragmentation of psychoanalytic theory can, in part, be understood in terms of the problematic relationship that has evolved between that theory and clinical practice. My case, in brief, is that analytic theory is intended to help analytic practitioners to make sense of clinical phenomena and to guide interpretative and other interventions. However, the theories that practitioners actually rely on are specified beyond available data, and are weakened by their extensive reliance on induction: they often amount to no more than the observation that since a particular phenomenon has usually followed another thus far, they are likely to continue to occur together in the future. Clinical observation, irretrievably contaminated by theory-driven expectation, carries an inappropriate burden of validation. There is some truth to the quip that analytic clinicians understand the word *data* to be a plural of the word *anecdote*.

The clinical usefulness and persuasiveness of such inductive arguments makes it all too easy to raise the status of "clinical theories" to laws, and we gain the impression as we do so that we have a tool for understanding that not only makes sense to us, but also that works for our patients, and furthermore, one that is scientific. But uncritical faith in the scientific nature of analytic theory may lead to the petrification of analytic practice and the reification of constructs essential to clinical work. Theory has apparently diversified beyond the possibility of integration, and thus particular features of clinical practice—arguably, arbitrary ones—have become the sole means of retaining the identity of the theory and the profession.

Yet in the absence of clear injunctions about the aspects of practice that are genuinely theory driven, it becomes difficult to know what features of practice may be altered without threatening the entire theoretical edifice—just when the devastating condemnation, "Yes, but this is not psychoanalysis," becomes appropriate. The politically motivated illusion of a direct connection of practice to theory, coupled with the weak links that actually exist between theory and practice, may lead practitioners to be

overly cautious about experimenting with new techniques guided by their accumulated implicit understanding of the mind, since they cannot know what the theory does or does not permit.

If theory were tightly linked to technique, advances in theorization would have inevitably led to practical gains in terms of treatment effectiveness. I believe that a case for this would be hard to construct, however. I suggest that in fact, in analytic practice, theory serves to justify existing patterns of practice through analogy (e.g., the developmental metaphor that the patient's therapy progresses analogously to the developmental process); and a rigidly enforced code of practice serves to create an illusion of integrity and unity in a theory inductively elaborated almost beyond the possibility that useful connections to practice can be made.

This paper argues that practice should be liberated from theory, permitting theory to evolve in the context of radically modified patterns of practice. If theory were decoupled from practice, technique might progress on purely pragmatic grounds, on the basis of what is seen to work. Psychoanalytic theory of mental function could then follow practice, integrating what is newly discovered through innovative methods of clinical work. I believe that the database for this enterprise already exists in an implicit (as opposed to publicly recognized) analytic knowledge base that is being mined, but chiefly by clinical theoreticians who end up contributing to orientations that rival our own. This pragmatic, principally action-oriented use of theory, I suggest, would bring psychoanalysis more in line with modern, postempirical views of science.

THE EPISTEMOLOGICAL STATUS OF CLINICAL THEORY

Psychoanalytic theory is drawn from clinical practice. Three-quarters of a century ago, Freud (1926) set forth the relationship between treatment and theoretical development as an inseparable bond:

> In psycho-analysis there has existed from the very first an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficial results. Our analytic procedure is the only one in which this precious conjunction is assured. It is only by carrying on our analytic pastoral work that we can deepen our dawning comprehension of the human mind. This prospect of scientific gain has been the proudest and happiest feature of analytic work. [p. 256]

The wedding of theoretical development to clinical observations created a major epistemological problem for psychoanalysis that has been extensively reviewed and discussed (e.g., Edelson 1989; Meissner 1989), and here will be considered only in abstract terms. The relationship of clinical theory and practice is a philosophical problem, usually considered in the philosophy of science under the heading of *methodology*. The subject matter of methodology is defined in opposition to that of logic (Papineau 1995). While logic is the formal description of deductively valid reasoning, methodology covers all the reasoning we undertake that tends to fall short of the deductive. In making clinical judgments and decisions, we use arguments that may give us good reasons for believing in certain conclusions, but they do not compel acceptance in the manner that deductive arguments might.

All clinicians work with inductive inferences. Generally speaking, *induction* refers to any form of inference in which a move is made from a finite set of observations to a conclusion about how things generally behave. Although there are several forms of inductive inference, here I am concerned with simple, enumerative inductions which start from the premise that as one phenomenon has consistently followed another thus far, we may conclude that those phenomena will always occur together. By contrast, a *deductively* valid inference is marked by the fact that if what we infer from is true, it is quite impossible for what we infer to be false. For example, if we know that all poor children are unhappy

and that Joshua is a poor child, we can deduce that Joshua is unhappy. By contrast, from knowing that Joshua has been sexually abused by his foster caregiver, we can induce that his precocious sexuality is due to an experience of maltreatment, but we cannot make a deduction to this effect.

In therapeutic work, we are confronted with a finite set of observations based on formal or informal assessments, as well as on the evolving treatment process. From such a sample, the clinician then moves to conclusions about how the patient generally behaves and formulations about why he or she does so. In practice, induction is made not simply on the accumulation of past observations about a particular individual, but on formalizations of past cases by other clinicians in so-called clinical theories. We consider theories to lend support to inductive observations because we assume that theories imply that the number of observations on which an inductive inference is based is considerable, and this somehow lends weight to the conclusions. In such considerations, however, we are merely applying inductive arguments for induction. We are arguing that inductive arguments are acceptable clinically because they appeal to us.[1]

Even if our premises do not logically guarantee our conclusions, they normally turn out to be true anyway. Arguing that inductions are generally acceptable because our experience has shown them to work so far is itself an inductive argument. Even if observed patterns have tended to hold good so far, what guarantees that they will continue to do so, except for our unconscious desire that they should? As Bertrand Russell (1967) argued, it can hardly help to observe that past futures have conformed to past pasts. What we want to know is whether *future* futures will conform to future pasts. The argument that past co-occurrence has

[1] As I shall postulate later, this intuitive appeal may have profound importance in the context of a more sophisticated epistemology specific to the acquisition of understandings about the mind. Here I am concerned only with illustrating the relatively weak logical foundations of psychoanalytic theory based on clinical experience.

probative value is merely rhetorical; it does not prove anything and can have little credibility.

Sensing the logical weakness of our position, we have tended to raise the status of "clinical theories" to laws, and have claimed to explain the patient's behavior by using something akin to Hempel's (1965) "Covering-Role Model": Given that certain initial conditions are satisfied and covered by a specific law that also specifies consequent events, a specific event that is accompanied by the initial conditions is considered to be explained by the law. Because they involve deduction via a law, such explanations are termed *deductive-nomological* explanations. This process has all the appearances of a piece of deductive reasoning. But such explanations do not rescue psychoanalysis from the problems of induction (Johnson et al. 1999), since the relevant "laws" were actually established by induction from past observations of results.

In fact, most clinical laws are only probabilistic (Ruben 1993), and therefore, they allow only inductive, statistical explanations, rather than deductive-nomological ones. While we know that child mistreatment can give rise to behavioral disturbance, for example, this is by no means inevitably the case (Sameroff 1998; Sameroff and Fiese 2000). The "Covering-Role Model" thus has crucial philosophical limitations, and the impact of these is well illustrated by the history of theory in analytic clinical practice. The central point here is that the key function of theory for practitioners is to *explain clinical phenomena,* but it is not an adequate tool for genuine deduction.

CLINICAL TECHNIQUE IS NOT ENTAILED IN PSYCHOANALYTIC THEORY

It is my impression that analytic clinical practice is not logically deducible from currently available theory. There are several reasons for this.

First, analytic technique is known to have originally developed on a trial-and-error basis. Freud (1912b) willingly acknowledged this when he wrote: "The technical rules which I am put-

ting forward have been arrived at from my own experience in the course of many years, after unfortunate results had led me to abandon other methods" (p. 111). Free association, for example, is acknowledged by Laplanche and Pontalis (1973) to have been "found" (reached empirically), rather than deduced (p. 227). Similarly, Klein's (1927) and Anna Freud's (1926) discovery of play therapy could hardly be considered to have been driven by theory. More recently, Kernberg (1975) made the case for his modified technique with borderline patients by referring to what "clinical experience has repeatedly demonstrated" (p. 91) and the incidental findings of the Menninger Foundation Psychotherapy Research Project (p. 82). Similar acknowledgments to empirical derivation were made by Kohut and Wolf (1978, p. 423) and Hartmann (1951, p. 33).

But most technical developments are based on ordinary daily experience. For example, Kleinian analysts have learned to emphasize the interpretation of defense and to be a great deal more cautious in how and when they interpret envy or destructiveness. Some British Independent psychoanalysts have determined that fostering regression is not as successful as was once hoped (Rayner 1991). Most British analysts have come to give priority to the interpretation of affect and mental state in the here-and-now relationship (Sandler and Dreher 1996).[2]

Second, innovative clinical procedures may, of course, be theoretically guided. If this were more frequently the case, we would expect practices to have been logically derivable from theory, at least in some instances. Such claims have commonly been made (e.g., Freud 1904, p. 252; Kohut 1971, p. 264). The following specific example will suffice here. Gedo (1979) boldly stated that: "Prin-

[2] I mention these technical changes with approval of both the specific technical advances referred to and the process by which they came to benefit practice. The negative tone of my argument is addressed entirely to the claims, rival to mine, that changes in technique have been driven by increased psychoanalytic understanding of the mind or improved understanding of the process of therapeutic change (e.g., Terman 1989).

ciples of psychoanalytic practice . . . [are] based on rational deductions from our most current conception of psychic functioning" (p. 16). In fact, his book made the claim that the unfavorable outcomes of developmental problems can be reversed "only by dealing with those results of all antecedent developmental vicissitudes that later gave rise to maladaptation" (p. 21). What sounds like, and is claimed to be, "a rational deduction" is in fact a hypothesis, emphatically stated to disguise the absence of a logical argument to support it. It is one thing to assume that development follows an epigenetic scheme, but quite another to claim that in therapy, all earlier vicissitudes must be dealt with. There is no evidence for Gedo's claim, even from within the self psychological theoretical camp from which the suggestion emanates (Kohut 1984; Terman 1989). In fact, the differences between Kohut's and Gedo's therapeutic approaches illustrate the absence of a deductive tie between the epigenetic model to which self psychologists subscribe and the technical propositions that are claimed to relate to these. For example, Kohut (1984) explicitly recommended that, under certain circumstances, developmental vicissitudes, such as narcissistic traumata, should be left alone (pp. 42-46).

This example is representative of many widely respected claims for the theoretical grounding of recommended therapeutic techniques or principles. For example, Kernberg (1976) insisted that "an important consequence" of his admittedly inspiring and highly original theoretical formulation concerning the nature of borderline personality disorder is that the therapist's active focus must be on the mechanism of splitting "before any further changes can be achieved with such patients" (p. 46). However, Kernberg failed to demonstrate the claimed deductive relationship. From the same psychoanalytic institute (Columbia), and previously from the same psychiatric hospital (Menninger), Schafer (1983) recommended delaying interpretations altogether for long periods (pp. 165-180). In fact, the most exhaustive exploration of the long-term findings of the Menninger Psychotherapy Project could be argued to have overturned many of the findings of the

original Kernberg et al. report (1972).[3] The existence of quite contradictory therapeutic alternatives indicates that the theory of borderline phenomena proposed by Kernberg, however persuasive, cannot be connected to any singular approach to therapy through readily discernible deductive steps.

Third, analysts do not understand, nor do they claim to, why or how their treatment works (see, for example, Fairbairn 1958, p. 385; Fenichel 1941, p. 111; Kohut 1977, p. 105; Matte Blanco 1975, p. 386; Modell 1976, p. 285).[4] Is it conceivable that such a state of affairs could arise if practice were logically entailed in theory? Surely, if this were the case, a clear theoretical explanation for curative action would be readily forthcoming. The nature of the therapeutic action of analysis is a recurring theme of psychoanalytic conferences, starting, perhaps, with the Fourteenth International Psychoanalytic Association Congress in Marienbad (Glover et al. 1937), where Glover, Fenichel, Strachey, Nunberg, and Bibring crossed swords. Since that time, there has been a symposium on this topic at about ten-year intervals, alternating

[3] In fact, this study showed the powerful effects of specific therapy allegiances (Luborsky et al. 1999), with each report finding evidence for the theoretical position of the author. Thus, while Kernberg (Kernberg et al. 1972) concluded that expressive therapy was superior to supportive therapy for patients with borderline personality organization (BPO), others found expressive therapy to be comparable to supportive therapy for BPO (Horwitz 1974), and still others reported that neither of the treatments had integrity (delivered as prescribed)—namely, Wallerstein (1986) showed that, of the forty-two subjects randomly assigned in the trial, thirty-eight had treatment of both types. Other reports further complicated the results, claiming that the different forms of treatment should not be compared because they were interdependent; for example, transference interpretations appeared to be more helpful after supportive interventions had occurred (Horowitz, Rosenberg, and Bartholomew 1996). It is noteworthy that the ratios of patients in treatment in the Menninger Psychotherapy Project to publications are: 8.4 patients per book, but only 0.7 patients per scientific paper.

[4] One of the most intelligent commentators on psychoanalysis, Cooper (1989), concluded his overview of the field by pointing to

> . . . a change of view from the earliest days of analysis, when a single therapeutic element was sought to explain the effects of analysis, to the present, when we see the therapeutic effect depending upon multiple interacting processes, none of which can be assigned clear priority in our present state of ignorance. [p. 24]

between the International and the American Psychoanalytic Association meetings. At each of these meetings, speakers have almost ritualistically asserted that the way analysis works "is not adequately understood" (Fairbairn 1958, p. 385), or have indicated "an urgent need for further research by psychoanalysts" (Cooper 1989, p. 24). The state of epistemic affairs is well summarized in Matte Blanco's (1975) words: "The fact is that nobody has, so far, succeeded in establishing with great precision what the factors are and how they combine with our understanding to produce the cure" (p. 386). If the practice were logically entailed in theory, we would undoubtedly have a clear—or at least clear*er*—theoretical explanation for therapeutic action.

Fourth, as has already been suggested, psychoanalytic practice in essence has changed little, if at all, since Freud's (1912a, 1912b, 1913) original descriptions in a few brief papers before the First World War. This state of affairs has been classically acknowledged (Glover 1968, p. 115; Greenson 1967, p. 3). For example, Glover (1968) stated: "For certainly, and despite a multiplicity of articles on the subject of technique . . . no very radical advances have been made in the therapeutic field" (p. 115). Because, traditionally, analysts have not recorded their clinical work, such assertions are hard to prove. However, extensive supervision based on the reported psychotherapeutic process, which forms the core part of psychoanalytic training, serves to ensure that analysts, at least in the course of training, adhere relatively closely to so-called traditional technique. This is not to say that there have been no stylistic changes in analytic technique, but these have left the fundamentals (free association, interpretation, insight, focus on transference and countertransference) largely unaffected. Over the same century, enormous theoretical advances have taken place, so that it is hardly practical to attempt to provide integrative summaries of analytic theories. The discrepancy in the rates of progress between theory and practice is quite remarkable, and would be hard to understand were it not for the relative independence of these two factors.

Technique, of course, has changed somewhat, and I am not suggesting that current technique is identical to that which Freud

evolved, or to that which was generated by key formalizers of psychoanalysis following Freud's death. There is no doubt that change has occurred, but current technique is far more recognizably Freudian than current theory. Suggested technical changes have been relatively minor (e.g., the value of early transference interpretation, or of self-disclosure) and not radical (such as the use of psychodrama in place of free association to reveal unconscious representational systems, the abandonment of the interpretation of unconscious content in favor of psychoeducational strategies, or the use of behavioral or cognitive behavioral adjuncts to therapy). Radical technical innovations are seen as taking the proposer beyond the pale, as if such modes of intervention could no longer be considered to fall within the domain of psychoanalytic theoretical explanations.

But of course, psychic change needs to be explained, whatever its cause (Fonagy 1989). If the current argument is sound, change brought about through the application of classical analytic technique is no easier to account for than change following behavior therapy or religious conversion, and the "inseparable bond" between theory and practice can be maintained only through powerful rhetorical claims. The tendency to disguise the loose coupling of theory to practice behind rhetoric is pernicious because it serves to close the door on imaginative clinical exploration by fostering an illusion of a theory-based technical certainty: "We know what needs to be done because we know how it works and why." Furthermore, the converse is also true. New theoretical ideas can claim acceptance and legitimacy in public theory through a tracing of their origins to relatively unmodified therapeutic technique, thereby reinforcing the immutability of the latter. The slow development of analytic technique is, I believe, in part attributable to the tendency of inventors of new theories to seek validation for their hypotheses via the congruence of new ideas with accepted clinical practices. The practices are claimed as uniquely effective and unchangeable, at least until a new theory evolves.

Fifth, the thorny issue of therapeutic effectiveness might also imply an independence of the domains of theory and practice.

There is relatively little evidence to support the clinical claims of psychoanalysis as a viable treatment for psychological disorder (Fonagy, Kachele et al. 2001; Fonagy and Target 1996; Gabbard, Gunderson, and Fonagy, in press; Roth and Fonagy 1996). There is much stronger support for many of its theoretical claims (e.g., Bucci 1997; Fonagy, Steele et al. 1993; Westen 1999), including those related to the treatment process (e.g., Luborsky and Luborsky 1995). While accepting that a lack of evidence for effectiveness does not imply a lack of effectiveness, the discrepancy may also be explained by the assumption that practice is not entailed within theory. The evidence that exists is for a theory of mind that contains unconscious dynamic elements. Evidence is, however, lacking for the translation rules for moving from psychological theory to clinical practice.

For example, work from other laboratories and mine has provided good evidence for the psychoanalytic notion that a parent's experience of having been parented is transmitted to the next generation (e.g., Fraiberg, Adelson, and Shapiro 1975), determining aspects of the nature of the child's relationship to that caretaker (Fonagy, Steele et al. 1993). There is far less evidence to suggest that addressing the parent's past conflicts in a psychotherapeutic context might help him or her to establish secure attachment relationships with the child (van IJzendoorn, Juffer, and Duyvesteyn 1995). Actually, the theory says little about how knowledge concerning transgenerational relational links may be most effectively used in a clinical context. Does it necessarily follow from analytic theory that insight by the parents into their own childhood experience would be the best way of preventing transgenerational transmission of maladaptive patterns of relating? Or is the closest analogue to insight-oriented psychotherapy chosen by analytic clinicians almost automatically, since this is what serves to define their theoretical identity?

Sixth, as has been implied, it has been impossible to achieve any kind of one-to-one mapping between therapeutic technique and theoretical frameworks. Interestingly, it is as easy to illustrate how the same theory can generate different techniques as how the

same technique is justified by different theories. For example, Campbell (1982) demonstrated that clinicians with broadly similar theoretical orientations differed in the extent to which they adopted a position of technical neutrality, shared their thoughts and feelings with patients, or gratified their patients' primitive developmental needs. By contrast, it is equally striking to observe that clinicians using very different theoretical frameworks can arrive at very similar treatment approaches. For example, Kernberg's (1989) work with borderline patients has much in common with the work of those who practice according to a Kleinian frame of reference (Steiner 1993). Both these observations imply that practice is not logically entailed within theory.

Seventh, one may legitimately ask the question: What is psychoanalytic theory about if it is not about psychoanalytic practice? The answer is that it is predominantly about the elaboration of a psychological model, and the way in which that model might be applied to the understanding of mental disorder—and, to a lesser extent, to other aspects of human behavior (e.g., literature, the arts, history, and so on). Freud's corpus may be an eloquent example: his technical papers take up far less than a single one of the twenty-three volumes of his collected psychological writings. The value of theory for the analytic practitioner consists in elaborating the meaning of behavior in mental state terms that can then be communicated to the patient. How such elaboration is done—or indeed, whether it is helpful to do it—is not readily deducible from the theory.

PRACTICE AS INSPIRATION FOR THEORY AND THE OVERSPECIFICATION OF THEORY

Having claimed that in psychoanalytic work, practice is not logically entailed in theory as is generally claimed, I would like to briefly review some ideas concerning the nature of the actual relationship between these two domains. Naturally, I recognize that

it is inconceivable that no relationship between theory and practice exists. Theory orients clinicians in their observation, description, and explanation of clinical phenomena. It is inevitable that these will influence technique, even though no logical connection exists between the two. This relationship is particularly clear in psychoanalytic attempts to provide nosologies or classification systems for psychological disorders (e.g., A. Freud 1965; Kernberg 1989). Such categories are evidently theory driven and are commonly used to construct "models" or analogies intended either to suggest or to rationalize therapeutic principles. Models are also used to draw likely inferences to therapeutic interventions. Models of development, models of the mind, and models of disorder have all been used in this way. It should be clearly stated that these are common-sense, inductive arguments, rather than formal deductions; they may have "face validity," but are not compelling.

As analysts, we have often made the mistake of assuming that we are doing more than model construction—that our practice is theory based. The price to pay for such an assumption may be the petrification of practice. In the absence of clear injunctions about the aspects of practice that are genuinely theory driven, it becomes difficult to know which aspects of practice are grounded in valid theories, and which may be dispensed with. For example, if on the basis of Freud's (1923) structural model of the mind, it is suggested that psychic change may be attained only by changes in the patient's defenses, or by the strengthening of those defenses (Fenichel 1945), then all interventions that do not entail one of these two modalities must be ruled out of the analytic clinical armamentarium. This was the classical Anna Freudian position taken in relation to Klein's so-called deep or direct interpretations of unconscious wishes (King and Steiner 1991).

Yet the rationale for this technical stricture rests in the hydraulic metaphor of early Freudian thought (what French psychoanalysis has labeled the *first topography),* and it is not truly explained by the structural theory (the *second topography).* This is not to say that the recommendation itself, that of avoiding "deep" interpretations, was not a sensible one. In fact, it is my impression

that Kleinian clinicians have tended to move away from the direct interpretations of unconscious desires (see Spillius 1994). The burden of this argument is that the illusion of direct connection to theory, coupled with the weakness of the real links between theory and practice, may lead practitioners to be overly cautious about experimenting with new techniques, since they cannot know what the theory does or does not permit.

There are obvious problems in the evidential base of many analytic theories that might preclude a direct relationship to technique. Few standards, other than plausibility and coherence, currently serve as gatekeeper criteria to the body of public theory in psychoanalysis. Clinical work is infinitely rich, and can thus be an inexhaustible source of inspiration. A concerted attempt to design more stringent conditions for permitting speculations (however inspired) to enter the body of theory may serve to impede creativity in the short term, but may enhance productivity in the long run. For example, what would have happened in the past if clinically based theoretical papers had been required to describe at least twenty treatment cases each, homogenous from a particular standpoint, rather than one, in order to be considered acceptable support for a particular theoretical innovation? Would the introduction of this criterion have precluded important theoretical advances? I cannot imagine that it would be hard to gather twenty cases that clearly illustrate projective identification at work. Certain more specific claims—such as "projective identification is a behavioral reenactment in which the patient unconsciously 'identifies with the aggressor,' a parent, while the analyst experiences the feeling of the child being acted upon" (Porder 1987, p. 450)—might be harder to establish. Surely, one consequence would be the publication of fewer psychoanalytic papers, fewer journals, and perhaps more multiauthored articles. Perhaps, even more important, there might be fewer theories, but a stronger link between those that exist and the clinical practice that is followed.

The argument that theory and practice are not interdependent appears to fly in the face of the common observation of the

valuing (perhaps even idealizing) of theory by practitioners. The relatively healthy state of psychoanalytic book publishing over the past century speaks directly to this.[5] Nothing that has been said so far negates the existence of a close relationship between technique and theory. While there is little to suggest that a direct or explicit relationship (such as "theory dictates technique") currently pertains or is likely to be attained in the near future, more subtle—but more profound—relationships between theory and practice are possible, and it is to one of these that I shall now turn.

In brief, I suggest that the real break of relationship is not between theory and practice, but rather between "scientific" theory and practice. The break between practice and theory has occurred precisely because of the overly close link between theory and practice, because in analysis, theory fulfills an important clinical function. To elaborate this point, we have to explore an aspect of the failure of analytic theory as a scientific theory.

So what has gone wrong with scientific psychoanalytic theorization? The answer probably lies in part in the way in which analysts have used practice inductively to generate theory. The analytic clinician is an interesting subject of study in this context, partly because, in the absence of alternative (experimental) strategies for verifying theories, clinical work becomes the chief source of theory building, and partly because increasingly forceful critiques of psychoanalysis over the past half century have highlighted the dangers of its epistemology (Crews 1995; Grünbaum 1984).

As philosophers have relatively recently concluded, one facet of Freud's brilliant insights was the extension of common-sense or folk psychology to nonconscious mental functioning (Hopkins 1992; Wollheim 1995). Cognitive neuroscience has revealed that most of the work of the brain is nonconscious (Kihlstrom 1987). Freud (1900, 1923), having recognized the importance of this fact in the development of psychopathology, advanced two

[5] The decline in book publishing over the past decade and a half is more likely a consequence of declining interest in psychoanalysis as a mode of clinical intervention, rather than a declining interest in theoretical publications on the part of those who continue to be interested in analytic or analytically oriented practice.

radical propositions. First, mental health problems (by which he was probably referring to behaviors or phenomenological experiences that either the individual or those in his or her immediate social surroundings complained about) may be understood in terms of certain nonconsciously experienced mental states—that is, beliefs and desires (Freud and Breuer 1895). Second, the effective treatment of mental health problems could be undertaken if (and only if) the individual suffering from mental disorder was made aware of these nonconscious, and by definition maladaptive, beliefs or desires in an interpersonal context of considerable emotional intensity (Freud 1909, 1916). The two key principles of mentalization for Freud, then, were that intentionality is not restricted to consciousness, and that expansion of the capacity to think about desires, feelings, and thoughts—those of which the patient is unaware—is therapeutic when undertaken in the context of an attachment relationship.

Freud's argument turned out to have an intellectual potency that is arguably hardly equaled in the history of human ideas. From it followed the discovery of meaning in madness, the revolutionization of psychiatry, the emergence of a civilization where unreason and disorder could no longer automatically be disclaimed and discarded, the recognition of the importance of early childhood, and a developmental approach to the study of mind and the possibility to envision human creation (art, music, literature, even science) in its greatest complexity. But Freud "overspecified" his theory. He linked his discovery of pathogenic unconscious influence to specific contents that commonly created nonconscious conflicts of ideas, which in turn created and sustained problems of adaptation (e.g., unconscious conflicts concerning toilet training) (Freud 1905, 1920, 1927). Anna Freud (1974) went further when she attempted to establish specific links between types of childhood mental health problems and categories of troublesome nonconscious mental contents.

Of course, this simplistic implementation of a good theory had to be counterproductive. The range of psychosocial experiences that reach a common symptomatic endpoint (equifinality)

is probably limitless. Similarly, the same experience may antedate a variety of clinical manifestations (Cicchetti and Cohen 1995). Unfortunately, by overspecifying the theory, Freud laid psychoanalysis open to endless revisions and updating of aspects of theory that were never fundamental to his ideas (Fonagy and Target, in press). For example, Klein, focusing on infancy, was struck by the apparent destructiveness and cruelty manifested by normal (her own) children (Klein et al. 1946). Since the scientific methodology offering relatively firm data on infant mental states was not yet available (e.g., Stern 1994), she felt free to attribute extraordinarily complex ideation to the young infant (envy, projective identification, and the depressive position), without a genuine risk of contradiction. Other analytic clinicians (for example, Mahler; see Mahler, Pine, and Bergman 1975), whose interest was focused on somewhat later developmental periods, specified quite different central psychological conflicts (in Mahler's case, symbiosis, separation-individuation, and so on).

I am not claiming that these or the many hundreds of other ideas concerning unconscious causes of conflict (Kazdin 2000) were "wrong." It is very likely that both conflicts over destructive jealousy (envy) of a loved object, and the conflict between a desire for separateness and the wish to retain an illusion of union with a caregiver, are important assumptions about mental states in understanding minds in distress. The problem is rather one of trying to claim exclusivity for any or all of these ideas. As such specificity in relating theories to clinical work is rarely attained, new analytic theories are developed without systematic reference to the old as "supplemental" to the original theory. Thus, new ideas overlap with, but do not replace, the original formulation.

Psychoanalysts found a way around the empirical problems created by partially incompatible formulations that nevertheless needed to be employed concurrently. They loosened the definition of all the categories under consideration. The potential embarrassment of negative instances—where, for example, signs of unconscious hostility were *not* observed to lead to mood disorder—could be avoided if both the putative antecedent (hostility) and

the consequent condition (mood disorder) were to be only loosely defined (Sandler 1983). Disappointingly, yet inevitably, this has led analysts to embrace an antagonism toward operationalization and an explicit preference for ambiguity. Equally predictable has been the multiplication of theories, the rejection of parsimony as a criterion for eliminating competing ideas, the geographical specificity of particular theoretical traditions, the overvaluation of spoken and written rhetoric as criteria of validity, the polymorphous use of concepts, and ultimately a theoretical edifice that is beyond the power of any individual to summarize and integrate.

Here I am not pleading for an integrationist model (Goldfried 1995, 2001). Rather, I am suggesting that Freud's original, rich theorization is to blame for conflation by later analytic clinicians of the framework of psychological mechanisms implied by the theory with the specific mental contents that populate this structural framework. Unconscious conflict is core theory,[6] and as such could probably be logically linked with recommendations about technique. Envy, oedipal rivalry, separation-individuation conflicts, and narcissistic traumata are elaborations at a different level, one of clinical observation, and are therefore too confounded with practice to permit deductive inferences to clinical method.

[6] Some propositions within any scientific theory are likely to be protected from refutation—to be treated in this sense as unfalsifiable (Lakatos 1970). Such propositions are considered to constitute the *core* of a scientific theory. The theory refers to "unobservables" and the principles that govern their causal interaction. The principle of methodology that justifies protecting core theory from refutation is the central role that such an aspect of theory plays in making predictions. The refutation of core theory would paralyze the theory; experiments could not be constructed because there would be nothing to put to a test. Core aspects of theory cannot be given up because they are needed to organize action, and therefore, appropriately, will not yield to anomalies alone, but only to alternative theories good enough to substitute for them. Arguably, core psychoanalytic theory was not given up by social scientists throughout the twentieth century, despite numerous anomalous observations, because nothing existed to replace it. The emergence of cognitive theory and therapy, together with neuroscience at the end of the twentieth century, began to threaten the core theory because they could provide viable alternatives that could be seen to occupy similar positions within the understanding of human behavior.

That one person (the analyst) thinks about what appear to be gaps in the other person's (the patient's) understanding of a life situation—making the unconscious conscious—is core theory. What that situation is, whether the therapy itself (the transference) or life outside (the external world), may be less intrinsically relevant. There are basic structures of personhood that define the clinical enterprise. That this is overspecified in most psychoanalytic theoretical accounts is clear from the happy coexistence of the many hundreds of apparently equally efficacious alternatives that have little in common with each other, beyond the dual principles of the focused elaboration on nonconscious intentionality and the intensity of the interpersonal context within which this happens.

In Peter Schaffer's play about Mozart, *Amadeus,* King Joseph II explains his dislike of Mozart's production by saying: "There were too many notes!" Many philosophers have felt similarly about psychoanalytic ideas. Wittgenstein (1922) wrote in his preface to the *Tractatus*: "What can be said at all can be said clearly, and what we cannot talk about we must pass over in silence" (p. 7). No wonder, then, that subjective experience has largely eluded psychological disciplines other than psychoanalysis. No wonder that analysts fear that the introduction of research methods from this barren world risks the destruction of the phenomena they cherish. Nietzsche talked of unpretentious truths discovered by means of rigorous method, opposing this method to metaphysics, which blind us and make us happy. Nietzsche here distinguished boring empirical fact from evocative narrative. Holding on to unpretentious truths demonstrates courage of a different sort to that shown by analytic investigations of the unconscious; it is a turning away from what is appealing. Whittle (1999) called it "cognitive asceticism" (p. 241).

The overspecification of analytic theory might be considered the primary cause of its current problem of fragmentation, which —at least according to the citation studies—appears to be beyond the limits of plausible intellectual integration. Core theory is again and again respecified by each generation of theoreticians, leading

to a kind of uncontainable exuberance of ideas that we learn, teach, and use as formal psychoanalytic theory. Luxuriating in an absence of parsimony is not an end in itself for the psychoanalytic scholar. Her or his determination to create new distinctions and elaborations is driven by the wishes of the consumers of theoretical ideas: practicing clinicians.[7] The clinician's daily task is to address the individual's self-narrative and to create (co-construct) a fuller, richer, more satisfying account than the patient has been capable of creating in isolation (e.g., Holmes 1998). Cognitive asceticism is of little relevance to the clinician whose principal task is to create a narrative that can fill the gaps in a person's experience of life.

Thus, theory has profound heuristic value for the clinician. Theories support understanding. Analytic theory is inherently and irretrievably inductive. It is derived precisely to elaborate a specific human conundrum. Analytic theories cannot be bound by the minimalist principles that are the residues of positivism because they would be of little value if they were. They are adventurous; they dig deep. They are acts of imagination about how our minds function that are judged principally according to how well they fit our own and our patients' subjective experiences (see Whittle 1999). Theory has to be overspecified in order to work, in order to capture one or another subtle aspect of an infinitely complex system: human subjectivity.[8] This is not to say that overspecified theories are not true, but the indication of their value rests in the subjective reaction of the clinician in the process of attempting to fathom the subjectivity of the patient.

[7] As the theoretician is most often also a clinician within the context of psychoanalytic theorization, the former has firsthand knowledge of the latter's unquenchable desire for new formulations, closer-fitting models, and increasingly convincing explanations.

[8] There is, of course, a built-in process of new theory creation in this dynamic. Theories will capture an aspect of subjectivity only while that subjectivity is unchanged. The very act of capturing it, however, inevitably changes subjectivity, creating a need to then recapture it in a new way. The process is complicated by its simultaneous occurrence at an intersubjective (patient–analyst) and cultural level. Thus, renewal, or at least change, might be required by a change of subjectivity at an individual or social level, with complex patterns of interaction between them.

THE ROLE OF THE IMPLICIT KNOWLEDGE BASE AND IMPLICATIONS FOR THE DEVELOPMENT OF INNOVATIVE TECHNIQUES

To sum up what has been postulated so far, I have argued that, because of the limitations under which analysts work and the massive burden of their historical tradition, direct links between theory and practice have been hard to establish. Specific claims have been made about the existence of these links—claims that are poorly grounded in fact and have led, in part, to the loose use of theoretical constructs, and have resulted in ossification of those aspects of practice that inappropriately carry the burden of defining the clinical discipline of psychoanalysis. While theory does not define practice, the fact that practitioners find theory useful has been used as validation of the extremely diverse set of ideas that currently constitute public psychoanalytic theory. The value of overspecifying the ideas at the core of psychoanalysis probably rests in their intuitive appeal to both analyst and analysand while the two are jointly engaged in the task of elaborating the life narrative of the patient, so as to make it more coherent and comprehensible.

So why do theories "feel right"—why are they believed to be "of value" or "useful," at least for a limited historical period? I suggest that this is the case because they are *metaphoric approximations,* at a subjective level for both analyst and patient, of certain types of deeply unconscious internal experience that pertains not to an idea, but rather to a mode of mental function, a mental process (Fonagy 1982; Fonagy, Moran et al. 1993).

There are examples of such theories in other sciences at early stages of their development. For example, the understanding of phonology through metaphor, which European grammarians of the sixteenth century developed (distinguishing light and dark vowels, soft and hard consonants, moist and unmoist ones), has been shown to be far from arbitrary. This classification system has been demonstrated by modern phonetics (I. Fonagy 1980, 1983,

2000) to be based on the actual functioning of the articulatory organs (mouth, tongue, vocal cords) as these sounds are pronounced, of which the early grammarians could have had only preconscious knowledge. Thus, "dark" vowels are those created at the back of the oral cavity, while "light" vowels are generated closer to the front (the source of light). The firing of muscle potentials (muscle tension) associated with the creation of "hard" consonants has been shown by electromyographic recordings to be more rapid when contrasted with "soft" consonants. "Moist" consonants are generated through contact between the wet surfaces of the tongue and the roof of the mouth. Thus, scientific metaphors in phonetics encoded (and expressed) preconscious understanding of sound generation. It satisfied grammarians as an account because of the fit created with nonconsciously available knowledge about the generation of phonemes.

By analogy, aspects of analytic theory may be thought of as theorists' attempts to use metaphors to grasp the nature of the mental processes and mechanisms of which they have no conscious knowledge, and which are not available to direct introspection. We should not accept simplistic critiques of metaphoric thought in psychoanalysis. Science regularly employs metaphor in the absence of detailed knowledge of the underlying process. Provided that metaphor is not confused with a full understanding —or, to use Freud's expression, the scaffolding is not mistaken for the building—heuristic considerations might outweigh any disadvantages of such employment. Thus, while there are wisdom and truth in our theories, these attributes will not behave like theories in modern sciences.

Analytic theories also impact us at an unconscious level. Each particular configuration of ideas fits with an inner experience. We are rich in theory because theory sustains clinical activity, and it is hard to imagine how this richness can ever be reduced, either by research or by other methods, without also compromising the quality of the fit between a psychoanalytic model of mind and subjective experience. This formulation of the role of theory fits surprisingly well with currently popular, postempiricist views of science and knowledge.

In postempiricist epistemology, it is accepted that empirical beliefs constitute a theory within which no exact mapping is possible between specific beliefs and particular experiences (Bolton 1999). There can be no sharp distinction between theory and empirical data. In the empiricism of Locke and Hume, knowledge was assumed to be derived from sense experience, where the latter is an unconditional given (Quine 1953). Sense experience was assumed to entail no activity on the part of the self. In modern postempiricism, by contrast, the self is seen as an active agent processing sense data into information that is *relevant to action.* Sense experience involves cognitive activity. Perception is assumed to be organized in the service of action, in order to yield hypotheses that might aid the planning of action.

An example of this would be the generation of expectations about the outcome of action. Such hypotheses ultimately aggregate to generate theory. But theory always betrays its origins as subserving action, never being "immaculate" in its conception. Theory is systemic in relation to experience, and sense experience always occurs in the service of action. Psychoanalytic theory, like any theory, unconsciously serves to organize action. The truth of a theory is thus no longer seen as something absolutely contained within the relation of the theory to an external reality; rather, the validity of a theory rests in its capacity to enable action. Knowledge is not an awareness of absolute facts, but the capacity to attain a goal within a specific context or setting. The North American tradition of pragmatism lies at the root of this postmodern, action-based epistemology.

Our view of scientific theories has changed from one of generalized, absolute, grand, omnibus accounts to more local, differentiated, specific rules used to guide action. Theory becomes a working, living, tightly organized but flexible set of assumptions, one that is not sharply separated from other bodies of knowledge. Basically, whatever works, whatever is needed to explain, can be integrated into the theory. I suggest that this postempiricist reconstruction of theory has not yet taken place within the public theory of psychoanalysis. It is held in a somewhat

mysterious, unexplored container of knowledge that one might call *the implicit psychoanalytic knowledge base*. Sandler (1983) and Sandler and Dreher (1996) drew attention to this almost twenty years ago. Anticipating many of these epistemological developments, Sandler (1983) explicitly suggested that public theory grew out of this implicit, nonconscious understanding of interpersonal and intrapsychic processes that clinicians normally achieve through engaging in intensive psychotherapeutic work, with the background of core psychoanalytic theory behind them.

A number of assumptions are implied by the current formulation of theory–practice links. First, that a nonconscious psychoanalytic knowledge base exists, probably built or superimposed upon the cognitive structures provided by a common-sense or lay psychology (Churchland, Ramachandran, and Sejnowski 1994). This all-important system for understanding the mind guides all of us (analysts, patients, children, and adults) through the great complexities of interpersonal interaction, and provides a knowledge of minds that is essential for self-awareness.

Second, for psychoanalysts, this knowledge base is massively deepened by clinical experience. The proximity to another mind afforded by analytic treatment will inevitably deepen an implicit, nonconscious, procedural, action-focused understanding of mental function.

Third, formal theory is essential in a number of ways, but the least important of these may be its traditionally desired function, that of organizing clinical observations. Core theory may be crucial in creating a foundation for interpersonal and intersubjective experience. Thus, Freud's assumption concerning nonconscious intentionality is undoubtedly essential if feelings and ideas outside of conscious awareness are to be brought into the realm of that which the analyst can explore. Perhaps an even more important facet of core theory may be to enable the analytic observer to remain "within range" of another subjectivity. We have come to understand much about intersubjective interactions and the interdependence of subjectivities—enough to appreciate that the close proximity of another subjectivity can potentially undermine the

robustness of the observer's self-understanding and self-awareness (Fonagy, in press). Core theory provides the scaffolding to withstand these pressures.

The psychoanalytic knowledge base has been and remains a vastly valuable reservoir for producing an understanding of people, and is thus a knowledge base with the power to guide action in the clinical context (technique). However, the epistemological tradition of psychoanalysis and its grand failure to eliminate aspects of theory that have not been helpful—its absolutist tendencies—have led to a situation in which this rich, implicit knowledge base cannot be regularly and systematically mined to guide therapy—that is, unless the action generated is consistent with some grand and slowly changing public theory. The separation of the public from the implicit theory has created somewhat arbitrary restrictions on theoretical development, together with a petrification of clinical practice.

This is not to say that the implicit, action-oriented knowledge base has remained unexploited within psychoanalysis. Elsewhere (Canestri, Bohleber, Fonagy, and Diatkin 2002), I have explored the ways in which implicit theory is used by clinicians to guide their daily work with patients. The most extensive use of this body of knowledge has not been by psychoanalysts. In fact, arguably, the knowledge base actually generated many, if not all, of the major advances of psychological therapeutic technique of the twentieth century. It is not an exaggeration to claim that approaches such as Gestalt, client-centered, some kinds of family therapy, most brief psychotherapies, and some forms of cognitive therapy (especially more recent ones) all originated from within the psychoanalytic knowledge base. Schema theory (Young 1999) is object relations theory by another name, and it is nothing short of a travesty that an effective therapy closely based on these ideas is not termed "psychoanalytic."

The way in which past relationship patterns impact on current relationships is an integral part of our knowledge base. Yet our epistemology limits the exploitation of this understanding to very specific therapeutic contexts. The knowledge base is mined,

often by analysts, but even as this takes place, the name *psychoanalysis* is withdrawn, as if this label has to be reserved exclusively for something in principle circumscribed, but in practice not defined at all. We need to be cautious over the matter of criteria of identity. What truly matter are general and specific features of content, not names. Theory and technique must be made open to elaboration. The priority is the derivation of effective and efficient procedures for implementing change, rooted in our understanding of mental function. We use an implicit source of knowledge, but our politically driven epistemology forces us to deny its relevance, and sometimes even its existence.

CONCLUSIONS

Let us return to Freud's basic discoveries. Fundamental to a psychoanalytic orientation is the notion that conscious awareness brought to bear upon patterns of thinking or behaving that are currently outside of consciousness has therapeutic value. The task of therapy is (a) to enhance the patient's capacity for thinking about the mental processes that underlie his or her feelings, thoughts, and behavior, and (b) to use such enhanced capacities to reflect upon patterns of interactions that are maladaptive and cause distress. The assumption of psychoanalytic technique is that making latent meaning manifest can initiate a process of change in understanding. Freud's theories and technique as to what this meant and how to do it have been modified over time.

There is much that can be said about the specific contexts in which an individual's problems emerge, but these have no necessarily causal relationship to the patient's current functioning. It is the capacity to reflect, and to arrive at meaning about conscious experience, that is inherently therapeutic, according to core Freudian theory. The specific understandings appear to be far more open to variation. There is a skeleton of a theory about the way new meanings are created by two human minds trying to fit together ideas and meanings about subjectivity, but it is the *how* rather than the *what* of this interpersonal process toward which

our growing understanding of therapy leads us. This theory is a combination of public and private (implicit) constructions.

It is the contention of the present paper that both these perspectives are valuable, but not necessarily for their "truth." The former (public) theory may be an overspecification of core ideas that may be at variance with other formulations, with equal claim to prompting therapeutically effective action. All such formulations are likely to contain within them metaphoric approximations of how the mind functions that have intuitive appeal to both clinician and patient. The latter, the implicit or private theory of the clinician, which we can only discern by observing the clinician at work, constitutes a particularly powerful reservoir of insights about the mind, but one that, at least thus far, has been inadequately exploited by formal psychoanalytic theorization.

I believe that much progress in psychotherapy outside of psychoanalysis has built on the intuitive understanding of the mind in therapeutic interpersonal relationships to develop effective intervention strategies that now compete directly with our own. Perhaps we have been overly generous with our insights. Perhaps it is high time that we analysts delve into our reservoir of psychological understanding ourselves, and take up the challenge of generating creative and efficacious new forms of intervention that are not modeled on classical analysis, that do not represent dilutions of a clinical model that might be outmoded—a model that was, perhaps, never particularly effective, and one that, in any case, has uncertain links with our understanding of mental function. Instead, we should focus on providing innovative, effective (and cost-effective) treatment models for treatment-resistant conditions.

If psychoanalytic theory is to have an influence on the psychiatric treatment approaches of the twenty-first century, it will do so only as the constraining influence of the attempt to tie clinical intervention to public theory is fully recognized. The following truths must be widely appreciated: (1) that accumulated psychoanalytic knowledge is far broader than we are commonly aware of, (2) that we know both much more and much less about the

mind than is codified in psychoanalytic texts, and (3) that we should approach creative modifications of technique not from the point of view of a Freudian superegoish father, tut-tutting at the breaking of imagined barriers and taboos, but from the perspective of a benevolent figure who encourages playful engagement with ideas, both in the sphere of individual therapy and in that of protocol development.

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CONCEPTIONS OF CONFLICT IN PSYCHOANALYTIC THEORY AND PRACTICE

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There are many different views of conflict in contemporary psychoanalysis, each with its own technical implications. After reviewing the psychoanalytic origins of the concept of conflict, the author discusses the diverse positions of four North American conflict theorists, each of whom offers a different view of the location of conflict both in the mind of the patient and in the material of the clinical hour. The role of conflict in the work of several relational psychoanalysts is then examined. A tentative approach toward integration is proposed.

INTRODUCTION

Time was when conflict was universally acknowledged as the defining focus of psychoanalysis, perhaps best captured in E. Kris's (1947) succinct definition of the subject matter of analysis as "human behavior viewed as conflict" (p. 6). This is no longer the case.

Nearly all contemporary psychoanalytic schools refer to conflict, but never in quite the same way. Some analysts, including some self psychologists, focus primarily on defects, deficits, and dissociations—or "vertical splits" (Kohut 1971, p. 176)—considering conflict to be a later developmental achievement, and in certain cases, a later focus for analysis. Some analysts, including some European ones, work with a topographic conception of conflict between a repressing agency and the ideas or affects that agency relegates to a sequestered unconscious. Some analysts, including

some relational ones, focus on conflicting self-organizations. Others, including Kleinian analysts, focus on conflict with internal objects. In each of these examples, the location of the conflict under examination and the components of the conflict are different. There is no consistent agreement about what is in conflict with what.

This is no less true within a single school than it is between one school and another. Contrast the way in which an analyst such as Arlow (1969) listens for underlying themes of unconscious fantasy, while another, Gray (1986), for example, using a similar model of the mind, focuses on the surface of the work for moments of conflictual interference. Between the two approaches are significant differences in the focus of attention, the clinical unit of attention, and the nature of the inferential and evidentiary process; in both, conflict is being observed at different levels of abstraction and clinical generalization.

And there are other complications. Increasingly today, we see conflict discussed in such a way that it appears that the analyst's focus is *conscious* conflict, conflict as experienced by the patient, in which case the term *conflict* is merely a synonym for conscious ambivalence. Like the different kinds of conflict, examined by different schools of analysis, conscious and unconscious conflict reflect different aspects of psychic life and are described at different levels of abstraction in the theories we develop to explain them.

To stay with this for a moment, note that conscious and unconscious conflict can be detected only by using different inferential processes. A patient may express conscious conflict, or experience inner conflict that is still clearly conscious, but unconscious or intrapsychic conflict is a theoretical inference on the part of the analyst, based on different methodology. That is, when an analyst speaks of intrapsychic conflict, as in the inferred unconscious conflict between a patient's wishes, defenses, and self-punitive trends, the process of gathering data, drawing inferences, forming hypotheses, and testing those hypotheses are different from those involved when an analyst maintains that "conflict is

always and only a subjective state of the individual person" (Stolorow, Brandchaft, and Atwood 1987, p. 88). Both the meaning of the word *conflict* and the methodology for understanding it are different in each of these instances. It is not that any of the various meanings of the word *conflict* are illegitimate, but in the current climate, they tend to be mixed into a common discourse, as if we were all speaking the same language, when in fact the components of the conflict are often unclear and inconsistent. Such conflicting uses create a confusion of tongues, especially when we are trying to sort out convergences and divergences in the current marketplace of clinical approaches. The result is a kind of false discussion in which similarities and differences between approaches may be more apparent than real.

We come by this confusion honestly, given the various methodologies we are taught in our institutes. And we can hear it played out in our literature. Is unconscious conflict only an invention in the mind of the analyst, an observation shaped by the analyst's theory? If not, are we are all observing intrapsychic conflict, but calling it by different names? Or are we all observing different kinds of conflict? Can the different views of conflict be integrated into a common model?

Contemporary discourse is made even more chaotic by the fact that the word *conflict* not only has different meanings, but is also used for different purposes. As I have suggested before (Smith 2001b), we have many such words in our vocabulary—*intrapsychic* and *interpersonal* come to mind—that, like patriotic flags or secret handshakes, are designed by their mere mention to establish lineage, demonstrate loyalty, and map out territory. Sometimes the word *conflict* is used for purposes of affiliation, to declare the author's allegiance to "conflict theory," whether or not the clinical material supports such a view; and sometimes it is used for the opposite purpose, to set up a kind of foil, deliberately or not, against which the author can define an alternative to conflict theory.

With these observations in mind, I would like to begin by briefly sketching the origins of conflict theory in the early writings

of Freud, and then to examine how the concept of conflict is used in the work of several contemporary theorists. It will be my contention that the ways in which analysts view conflict and where they locate it have a profound influence on analytic technique. I will look at a few examples from within the group that we think of as conflict theorists, and for contrast, a few from the relational group. Finally, I will ask if differences can be reconciled within a single model of the work.

FREUD

On May 21, 1894, Freud (1887-1904) wrote to Fleiss proposing four etiological categories of neurosis. These were: (1) degeneration, (2) senility, (3) conflagration,[1] and (4) conflict. Of the four, only the last has survived in a form recognizable today. "Conflict," wrote Freud, "coincides with my viewpoint of defense; it comprises the cases of acquired neuroses in persons who are not hereditarily abnormal." And then he added, "What is warded off is sexuality" (p. 75).

By December of 1895, Freud was already distinguishing two types of neurosis: obsessional ideas, based on "reproaches," and hysteria, at the "root" of which "there is always conflict" (p. 154). Here we glimpse the foreshadowing of what would become the structural model, with obsessional conditions providing a window into the self-critical components of conflict, and hysteria illustrating conflict between defenses and sexual wishes. Anticipating later complexities, he also referred to "some beautiful mixed cases" (p. 154).

By May of 1896, Freud had added another concept with implications for subsequent theoretical elaboration, when he described consciousness as "determined by a *compromise* between the different psychic powers which come into conflict with one another when repressions occur" (p. 189, italics in original).

[1] By "conflagration," Freud (1887-1904) meant cases of "acute degeneration" that occurred in "catastrophes" such as "severe intoxication . . . fevers [and] the prestages of paralysis," and that resulted in "disturbances of the sexual affects," leading thereby to neurosis (p. 75).

Although he did not use the term *conflict* in his seminal paper "The Neuropsychoses of Defense" (1894), Freud outlined several aspects of the conflict between repressing forces and the content repressed. Here we find conflict between an incompatible idea and an ego imbued with both moral judgments and defensive activity, the latter serving either to separate an incompatible idea from its associated affect, or to reject both the idea and the affect as one. Several years later, Freud (1900) would describe conflicts over wishful impulses. Note that these and other variations on them (see Rangell 1963) are all conceptions of intrapsychic conflict developed long before the advent of structural theory. From a topographic point of view, such conflict might be located at the points of censorship between the unconscious and the preconscious and between the preconscious and the conscious.

By 1900, Freud's use of the term *defense* had disappeared, to be replaced for a time by exclusive use of the term *repression*. As Brenner (1982) notes, during this period, Freud believed anxiety to be "a consequence of a failure of repression, not the motive of repression" (Brenner 1982, p. 6), as in his later concept of signal anxiety. It was not until 1926 that Freud gave to both anxiety and conflict the function in neurosogenesis that was conceptualized in the structural model, where conflict was located in the interaction among the three agencies of the mind: the id, the ego, and a superego now precipitated out of the functions formerly ascribed to the ego. At this time, the term *defense* resurfaced to cover a much broader range of ego functions than the topographic notion of repression. The clinical theory of defense was further elaborated in Anna Freud's 1936 monograph, and later in Brenner's (1982) model of the mind, in which any aspect of mental functioning could be used in the service of defense.

TOPOGRAPHY AND STRUCTURE

French psychoanalysts (e.g., Green 1999a) designate the shift from the earlier topographic to the later structural view of conflict as one from the first topographical to the second topographical

model, thereby emphasizing the continuity from the earlier to the later conceptualizations, which in their view form an integrated whole, much as in Freud's (1933) schematic diagram of the brain in which the three agencies are superimposed on the three topographic systems, Ucs., Pcs., and Cs. (p. 78). The contrast in terminologies used in France and in the United States highlights certain theoretical differences that have shaped the analysis of conflict across several continents.

In North America, under the influence of ego psychology, there has been a sharp break with the old model and the techniques associated with it. The replacement of the topographic with the structural point of view was advocated most clearly by Arlow and Brenner (1964), who felt that the former model led analysts astray, and that the two were "incompatible, that is, contradictory in important respects. It is our contention that the topographic and the structural theories can neither be used interchangeably nor side by side" (p. 55). In their description of the analyst's task, we can hear how the structural hypothesis has shaped their listening:

> The analyst is in a position to study a dynamic record of the patient's mental functioning. In this record, the analyst determines the specific contribution made by each of the components of the patient's conflicts. Wish, unpleasure, defense, moral imperatives, and realistic considerations are all represented in varying degrees. The analysts' interventions serve to clarify for the patient the interplay of these various components, to indicate the purpose each serves, and to trace their origins to their sources. [Arlow and Brenner 1990, pp. 679-680]

Compare this with the way Green (1999b) describes his listening to the analysand's communications:

> 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. The conflicts to which I refer do not con-

> cern the particular dynamic conflicts that would emerge in interpretation, but rather the way in which the discourse in turn approaches and moves away from a kernel of meaning, or a group of such kernels of meaning, which are trying to break through to the conscious. [p. 278]

When Green speaks of "kernels of meaning, which are trying to break through to the conscious," he is utilizing a topographic metaphor to describe the analyst's listening. The conflict of which he speaks lies just below the surface of the material, in the realm of what Freud called the *preconscious*. As Green notes, only later does Freud turn to "dynamic conflicts" of the sort Arlow and Brenner describe. In practice, many analysts, I believe, listen to both sorts of conflict simultaneously: for what lies just beyond consciousness, including the interferences that impede its emergence into consciousness, and for the dynamic or structural conflicts that may determine those interferences. These two forms of listening seem to coexist quite compatibly at different levels of abstraction, as long as the two theories from which they are derived are not brought into direct competition with each other.

Between the North American position and the continental one lies an intermediate position, voiced by Anna Freud, who, while instrumental in elaborating the ego psychological analysis of the defenses, felt throughout her life that one could use either the topographic or the structural model at different times, as the situation indicated: "I must say that in my writing I never made the sharp distinction between the two that later writers made, but according to my own convenience I used the one or the other frame of reference" (Sandler with A. Freud 1985, p. 31).

My point is that each of these conceptualizations, the purely structural view of conflict, the incorporation of the topographic and the structural within a single model, and the shift from one complete model to the other depending on the circumstance, will alter the technical demands made on the analyst and shape the technique that unfolds.

I would like to turn now to four contemporary North American conflict theorists, all of whom have made significant contribu-

tions to the analysis of conflict: Charles Brenner, Dale Boesky, Paul Gray, and Anton Kris. I will argue that each of them has stretched the structural model in different ways, and that, even though they share a fundamental theoretical commitment, each offers a different view of the location of conflict, both in the mind of the patient and in the material of the clinical hour, with consequently different technical implications. Following this, I will examine the view of conflict in the work of several relational analysts.

CHARLES BRENNER

In the most radical alteration of the structural hypothesis in contemporary conflict theory, Brenner (1994a, 2002) has eliminated the agencies of the mind altogether. In place of the id, ego, and superego, Brenner sees the components of conflict as (a) wishes or drive derivatives, (b) the unpleasure they evoke in the form of both anxiety and depressive affect, (c) defenses, and (d) fear of punishment or self-punitive trends—the fourfold components of compromise formation. This represents a shift both in the definition and location of conflict, from the "deeper," more abstract, inferred structures of the mind, to more immediate observations and less abstract inferences about the patient's efforts to minimize anxiety and depressive affect. For Brenner, every mental event is a compromise formation, with contributions from each of the four components.

This view of the ubiquity of compromise formation is derived in part from Waelder's (1936) paper, "The Principle of Multiple Function," wherein he notes that all "individual actions and fantasies" have an ego, id, and superego side or "phase" (p. 61). But Waelder's concept of the mind and of conflict itself was very different from Brenner's, even before Brenner eliminated the concept of the ego. Writing in response to Freud's (1926) "Inhibitions, Symptoms, and Anxiety," Waelder saw the ego as the "central steering" (p. 46) unit of the psyche, fielding demands presented to it from four sources: the id, the superego, external reality, and the

compulsion to repeat. In what would appear to be an extension of the concept of signal anxiety, Waelder suggested that the ego does not simply submit passively to the demands of each of these four "agencies" (p. 46), but that it uses each problem presented to it as a challenge to itself to overcome or assimilate both the demand and the agency from which that demand derives. Thus, "the principle of multiple function" referred to Waelder's view that every psychic act represented the ego's attempt to negotiate simultaneously among eight separate tasks, the four assigned to it by the other agencies and the four that it assigns to itself, and in that sense every psychic act had a "multiple function." Because it was impossible for the ego to satisfy all eight demands equally, Waelder suggested, "the character of each psychic act is thus proven to be a compromise" (p. 49); and he added, in a more philosophical vein, "Perhaps this affords us a possible clue to the understanding of that sense of perpetual contradiction and feeling of dissatisfaction which, apart from neurosis, is common to all human beings" (p. 49).

As Brenner (1982) points out, in contrast to his own view of compromise formation, Waelder did not see multiple function as the consequence of psychic conflict. The notion of the ego as the central steering unit, negotiating demands from eight separate sources, is a different conception from viewing the id, ego, and superego in perpetual conflictual interaction, as Brenner did in 1982—and even more at variance with Brenner's (1994a, 2002) more recent model, in which the ego is replaced by the *person*, and compromise formations are seen as the outcome of conflict among that person's wishes, defenses, and self-punitive trends in response to unpleasurable affect.

It is important to emphasize that in Brenner's conceptualization, unpleasurable affect in the form of anxiety or depressive affect triggers conflict; conflict does not cause unpleasurable affect. The conflict of which Brenner speaks is the conflict among the components of any given compromise formation. This distinction is frequently overlooked.

Normally, in everyday usage, instead of anxiety causing conflict, we think of anxiety as the *result* of conflict—the result, that

is, either of conscious conflict or of the failure of a defense against unconscious conflict. This is the intuitive position that Freud first elaborated when he thought of anxiety as due to the failure of repression. Notice that the anxiety in this case is conscious anxiety, whereas in Freud's later conceptualization, the signal anxiety that triggers unconscious conflict is itself unconscious. I note this distinction in order to indicate how far from a focus on the patient's conscious conflict Freud's later model and Brenner's elaboration of it prove to be, even though Freud, too, began his investigations with the consciously experienced manifestations of conflict and their conceptualization.

To some degree, the confusion over whether anxiety is the result or the cause of conflict is inherent in the structural model itself, as is evident when we ask: What is the hypothetical origin of signal anxiety? Brenner (1982) notes that both signal anxiety and depressive affect are stirred either by drive derivatives pressing for gratification or by the fear of punishment. In other words, unpleasure originates in (and in that sense results from) the conflict between drive derivatives or self-punitive trends and what was traditionally called the ego. For many years, this was what was meant by *intrapsychic conflict*, as the concept evolved from Freud's (1894) original notion of conflict between an incompatible idea and the ego. But in Brenner's modification, it is the next step—namely, the response to unpleasurable affect in the form of a conflictual structure called a compromise formation, with its various components vying for attention—that represents the conflict that is analyzed.

While steering us even further away from a more limited attention to conscious conflict, Brenner's modification of the structural model has the effect of conceptualizing unconscious conflict in terms of the more observable data of the clinical hour. Furthermore, in speaking of wishes or drive derivatives rather than drives, Brenner is making clear that we are dealing with the specific wishes of each individual person, not some generalized abstraction called a *drive*. One of the difficulties with the older approach was that it tended to imply that wishes were in one loca-

tion (the id), defenses in another (the ego), and self-punishments in a third (the superego), which parsed the analyst's attention in misleading ways. And it confused patients as well. I remember a man I once saw in consultation who had spent many not so fruitful years with a well-known analyst, who allegedly had told him that—and here the patient swelled with pride—he had an "id-superego conflict."

Brenner (1986) describes the effort he originally made to discipline his own listening, even before the more recent shift in his model:

> I know that I myself had to make a very conscious decision years ago to listen to whatever a patient said as a compromise formation. It required continuing effort to adhere to that decision until it eventually became the natural and easy, rather than the difficult and unnatural, thing to do. [p. 40]

The principle that every mental event is a compromise formation made up of wishes, defenses, and self-punishments, when carried to its logical extent, means that all wishes, defensive maneuvers, and self-punishments are themselves compromise formations, each in turn made up of the individual components of conflict. Such a formulation suggests a fundamentally altered view of the architecture of the mind, one that we might compare to the endlessly repeating patterns, known as fractals, that we find in the natural world (Smith 1998, 1999). While this apparently endlessly recursive theoretical structure is troubling to some of Brenner's critics (Boesky 1994), from a technical point of view, the analyst is now immersed in a kind of cascade of conflictually organized compromises. To be sure, the analyst can step back and focus on one compromise formation at a time, but he or she cannot escape the endless conflictual activity of the mind and its components. Brenner's modifications, then, while eliminating the more abstract terminology, and in that sense, simplifying the theory of mind, make the analyst's task considerably more complex, as he or she is no longer able to rest on the identification of id, ego, or super-

ego functioning in their separate domains—or, for that matter, on the identification and analysis of a defense or a wish without considering their subsidiary components.

Brenner's model has been criticized from a number of points of view. In addition to the argument that he opens the way to an infinite regress of the sort I have described, Boesky has suggested that if we do away with the abstract agencies, we are left with no way to speak of certain aspects of development:

> One of the advantages of the terms *id*, *ego*, and *superego* has been that it has allowed us to artificially but conveniently separate these functional organizations for purposes of discussion and investigation of the developmental fate of each of the three major functional components. [Boesky 1994, p. 512]

Brenner's answer is that what we sacrifice in convenience, we gain in accuracy, if we think of development simply in terms of the "pleasure-unpleasure principle, the components of conflict, and the resulting compromise formations" (Brenner 1994b, p. 526).

Goldberg (1999) has suggested that if everything is a compromise formation, the term loses all meaning: "Once you say that 'everything is,' you have also said that 'nothing is.' We can only study differences" (p. 400). It has also been argued that if we regard conflict as ubiquitous, a component of every mental event, the concept of conflict itself loses all specificity (e.g., Schmidt-Hellerau 2001). Similarly, Jacobs (2001, 2002) has recently suggested that my own position that countertransference, as a compromise formation, at all times simultaneously facilitates and interferes with analytic work (Smith 2000) is also misleading in its lack of specificity.

In my view, to say that conflict is ubiquitous, or that every mental event is a compromise, or that all countertransference simultaneously facilitates and interferes, need be no more misleading than to say that all matter is made up of molecules, atoms, and/or subatomic particles of different size, shape, charge, and function in interaction with each other. My analogy is not meant

to imbue Brenner's model with a sense of particulate structure that it does not claim, but rather to suggest that we are describing here the general architecture of mind, not the specific characteristics of each instance of conflict, compromise, or countertransference. As with any such general concept, the details of each specific example are essential—how one element in the periodic table is unlike any other, how one conflictual moment or experience of countertransference functions differently from any other. Without an underlying sense of how the mind in motion operates, however, we tend more readily to rest on reified abstractions and to miss the complexity of the very details that should be the focus of the work.

There is an epistemological problem that arises when we consider all mental events to be compromise formations. If the analyst's conflicts are embedded in every mental activity, including not only the analyst's observations of the patient, which form the basis for his or her hypotheses, but also how the analyst tests those hypotheses, the entire process of forming hypotheses and testing them would seem to be an endless recursion. In short, how does one know anything at all, or gain any "objective" purchase on anything, if every observation is thoroughly suffused by the analyst's wishes, defenses, and self-punishments—that is, by the analyst's subjectivity? This problem is, of course, not limited to Brenner's conceptualizations.

I have suggested previously (Smith 1999) that there is no absolute way out of this subjective loop, a profoundly humbling fact that has, I believe, played a role in modifying the analyst's sense of privilege, the idea that he or she is sitting in the catbird seat:

> From one intersubjective point of view, we try to unlock our solipsism by fully crediting the patient's view of our own activity and then reaching toward some shared agreement. From a more objectivist point of view we take in data from the external, from our observations of the patient, and we repeatedly test those perceptions against further perceptions to make increasingly reliable observations, even if that testing remains colored by our subjectivity. [p. 473]

Many have argued, however, that not only is there no absolute "God's-eye" objectivity, there are not even relative degrees of objectivity (Smith 1999). What such critics fail to take into account, in my view, is that, using Brenner's theory as an example, to say that every mental event is a compromise formation—or is "irreducibly subjective," as Renik (1993) has proposed—is not to say, as I note above, that every compromise formation is the same, or takes into account considerations of external reality in the same way, or has the same appreciation of the world at large. As Friedman (2002a) puts it:

> Believing that two plus two equals four makes me feel like a fair, rational person rather than the greedy sibling I know myself to be, but it is a different way of making me feel fair and rational than throwing bombs at plutocrats. It follows that we can be more or less rational and respect reality to a greater or lesser degree.

This combination of ubiquity and uniqueness bedevils some critics on another issue, namely, that Brenner's theory is not a theory of psychopathology. To quote Brenner (1982): "There is no sharp line that separates what is normal from what is pathological in psychic life" (p. 150). The distinction between normal and pathological compromise formations, Brenner argues, is based on the degree of pain and inhibition the individual suffers—the quantitative factor upon which Freud so often relied. The dividing line between the two is subjective and "arbitrary" (Brenner 1982, p. 150).

I have elsewhere suggested (Smith 1995) that there is a subtle contradiction in Brenner's argument when he suggests that the goal of analysis is to achieve "an alteration that results in a normal compromise formation in place of the pathological one that was formerly present" (Brenner 1994a, p. 479). The notion of replacing one thing with another has a developmental history in the theory of therapeutic action that begins with the concept of making the unconscious conscious and continues with the idea of "where id was, there ego shall be" (Freud 1933, p. 80), another

"replacement" concept that Brenner has argued is misleading. In this case, because he has already convinced us that there is nothing to distinguish normal compromise formations from pathological ones, except how well they are working, it is similarly misleading, I believe, to think of compromise formations as entities that can be replaced, as opposed to modified. The latter is clearly the intent of Brenner's principal argument. If compromise formations exist on a continuum with no dynamic difference between what is normal and what is pathological, it would seem that we might be better off without the terms *normal compromise formation* and *pathological compromise formation*, because they do not fit the clinical data well enough to qualify as separate entities and do not fit with the reality that the analysis of one's own conflicts and compromise formations is never complete, either for the patient or for the analyst. Contemporary conflict theory, as Brenner elaborates it, is indeed a theory of mind and of technique, not a theory of psychopathology.

Notice, however, that this is no less true of every other contemporary clinical approach. In contrast to the prominence of the earlier view that a particular memory or a specific unconscious fantasy might be considered pathological or pathogenic in itself (until it was, like a foreign body, rooted out and resolved through analysis), whenever we examine clinical evidence in contemporary analysis, we have very few theories of psychopathology, or for that matter of pathogenesis, that distinguish normal from pathological on a qualitative basis. If empathic ruptures and misattunements are the data on which we focus, we find them in all analyses and in all developmental histories; or if projective identifications or shifts from the paranoid schizoid to the depressive position are the developmental markers we examine in our patients' histories and the clinical lenses through which we view their associations, once again, they are ubiquitous. As with compromise formations, the line between normal and pathological in each of these approaches is an arbitrary and subjective judgment. At every turn, our current clinical approaches and the data they track silence our theories of psychopathology, or reduce them to quantitative considerations.

Returning to Brenner, there is, of course, no reason why one cannot step back and take a larger view of the patient's history and development, based on the way in which compromise formations have developed and shifted over time, but analyzing the components of any given compromise formation or any specific conflictual moment is, from a technical point of view, relatively ahistorical and adevelopmental. This is the technical consequence of Brenner's position. With no objective way to determine what is pathological and what is not, the analyst is encouraged to keep analyzing the individual components of each compromise formation and to let the analysis take its course.

DALE BOESKY

Boesky has in the main followed Brenner's views on matters of conflict, while introducing several clarifications and modifications of his own. In a recent presentation, for example, Boesky (2000) argues, successfully in my view, that it is specious to equate the term *intrapsychic* with a one-person point of view and the term *interpersonal* with a two-person point of view: "Both one-person and two-person events are possible to describe in either an intrapsychic or an interpersonal frame of reference."

Boesky defines the intrapsychic domain operationally. Advocating a particularly close reading of the patient's associations, he says, "It is this use of the patient's associations that I have principally in mind when I refer to the *intrapsychic domain*" (2000). Here the intrapsychic domain is defined neither as a place for, nor a condition of, internal experience, but rather as an aspect of the analyst's methodology, his or her "use of the patient's associations." The use to which Boesky refers was perhaps best elucidated by Arlow (1979), when he advocated attending in the patient's associations to context, contiguity, form, sequence, and the repetition and convergence of themes, including the repetition of similarities and opposites.

Boesky (2000) describes the observation of unconscious conflict on two different levels of abstraction.[2] While retaining a place in his theory for the interaction of id, ego, and superego as the components of compromise formation, Boesky suggests that what we "encounter clinically are conflicts between wishes . . . e.g., the wish to be assertive and the wish to be modest." This observation reconciles a conceptual problem. As Boesky reminds us, in years past, conflict was said to originate in the opposition between the ego and the id and "to speak of the id wishing anything was a logical impossibility since the id had no mental contents." (See also Schur 1966.) Even to speak of a conflict between the ego and a wish or drive derivative, as Brenner did in 1982, still presented a conceptual problem, because the ego is located on one level of abstraction, and wishes or drive derivatives are on another. When Brenner eliminated the reified notion of an ego, along with the other abstract agencies of the mind, the problem of mixing levels of abstraction was resolved. Boesky, on the other hand, solves the difficulty by shifting the locus of conflict to competing wishes in his clinical listening, while still retaining the concepts of ego, id, and superego in his theorizing.

In making this shift to conflicting wishes, Boesky advances yet another trend in contemporary psychoanalysis, as Brenner did before him, toward the more experience-near and toward the patient's more active agency. The language of conflicting wishes feels closer to the patient's subjective experience than do the components of compromise formation. Boesky is not alone in advocating this shift. We hear it as well in Renik's (2000) work, which, for all the postmodern attention it has garnered, remains

[2] It is important to note that when we speak of abstractions or levels of abstraction, we are not referring to disembodied theoretical entities; rather, abstractions are attempts to represent some aspect of the patient's experience. It might be said that any time anything is named either by the analyst or by the patient, it becomes an abstraction; before that, it is simply unnamed experience. As Friedman (2002b) puts it, "Abstraction means drawing out an aspect from a concrete something," which implies that all of analytic work can be seen as the attempt to wrestle one abstraction or another from the patient.

firmly grounded in contemporary conflict theory. I would like to suggest that, however powerful this clinical tool is, in locating our listening in the realm of conflicting wishes, Boesky tends to shift our understanding not simply of the analyst's technique but of the very nature of the conflict he is analyzing. Let me try to explain.

Brenner noted in *The Mind in Conflict* (1982) that "however disparate their aims, wishes that originate in the drives can be gratified in succession or even simultaneously without conflict" (p. 33). The one exception occurs when one drive derivative (or wish[3]) is defending against another. In focusing on conflicting wishes, then, it would seem that Boesky (2000) is moving the focus of inquiry to the defensive activity of the mind. We can see this in the example he gives, "the wish to be assertive and the wish to be modest," which translates the defensive component of modesty into wishful form. If doing so translates an unconscious defensive maneuver into a conscious or preconscious wish, it may engage the patient's sense of agency and shift the inquiry to a point closer to the patient's conscious experience than the cascade of compromise formations that hover behind the patient's wishful experience.

To be consistent with this approach, the analyst would have to translate all the components of conflict into wishful ones—not so difficult a task—framing as wishes not only the defensive, but also the self-punitive, components of compromise formation as well. While "the wish to be modest" is an example of the former, the wish to relieve guilt, or more directly, to suffer various forms of pain and inhibition, would be an example of the latter. Moreover, as I have already noted, if we were to deconstruct any individual wish, we would see that each is itself a compromise formation—the wish to be modest, for example, stemming not just from the defensive satisfactions of avoiding punishment for assertiveness, but also from the wish for pleasure from more passive

[3] Brenner (1982) uses the terms *drive derivative* and *wish* interchangeably: "A drive derivative is a wish for gratification" (p. 26).

and masochistic (self-punitive) gratifications. Notice that in so doing, we would inevitably be comparing wishes of different orders: unconscious wishes, for example, coming into conflict with more conscious ones.

Focusing on the level of competing wishes, then, encourages the analyst to work in what was formerly designated topographically as the *preconscious zone*, or as Gardner (1983) puts it, "at edge-of-awareness" (p. 14), and tends to direct the analyst away from the cascade of conflictual components encountered in Brenner's model. But if there is a technical gain in immediacy, is there also a loss? In focusing more deliberately on competing wishes, is the analyst less likely to mine all the data for the unconscious material that lies *behind* each compromise, thus minimizing what Poland (1992) has described as essential—"aiming for the deep" (p. 391)?

I say this knowing that I am, to some extent, splitting hairs. I doubt that Boesky is thinking only of conflicting wishes as he analyzes. The analyst's mind is far too restless and active an agent for that, constantly listening at different levels of abstraction, now focused on the patient, now on the analyst, now on competing wishes, now on the individual elements in each compromise. (For this reason, the mixing of levels of abstraction may not be as confusing in the clinical moment as it is upon subsequent theoretical reflection.) We might think of the conception of the cascade of compromise formations and their individual components as more suited to the data-gathering stage of the work, that phase of immersion in the patient's manifest material that yields information from a wide variety of sources. Framing the conflict in terms of conflicting wishes, on the other hand, may be more suited to the interpretive stage, where it might help to enlist the willing patient's cooperation in the analytic endeavor, at the same time that it risks stimulating renewed resistance by imputing responsibility to a patient that he or she may not accept.

There is always a problem in reconciling how we think theoretically with what we encounter clinically. In this regard, I would

emphasize again that the notion of a single compromise formation is a theoretical entity only, a kind of primary particle that cannot be encountered clinically, except as a hypothesis in the mind of the analyst. But there may be therapeutic value in attempting momentarily to isolate a single compromise formation in Brenner's terms, or a single wish or pair of wishes in Boesky's, as there is in identifying the repeated expression of a single unconscious fantasy, as Arlow might—as long as we remain aware that these are all artificial constructions that appear as isolated entities only in the mind of the analyst, not in the life of the patient. I would add that one of the values of maintaining a focus on conflict and compromise is that it allows considerable flexibility for the analyst to shift focal lenses, as I am doing here, gathering data at many different levels of detail, thereby ranging within many "hierarchies of attention" (as Boesky [2000] puts it), to include as much observational data as possible within the predominant focus.

PAUL GRAY

As I indicate in the introduction to this issue (Smith 2003), if we ask where theory "sits (or hides) in the mind" (Friedman 1988, p. 9), for many analysts, it seems to sit near the back or perhaps somewhere to the side, a guide but not an insistent one. Gray, on the other hand, has moved the theory of conflict and compromise to the forefront of the analyst's mind at work, where the notion of conflictual interference with the expression of drive derivatives becomes a kind of filter through which he views the patient's associations.

Gray (1973, 1982, 1986) teaches an approach to analytic listening that pays "close process attention"[4] (1996, p. 88) to the surface of the patient's associations, and thereby to psychic activity within the hour itself. He supports Anna Freud's (1936) rec-

[4] For a number of years, Gray (1991) referred to his method as *close process monitoring*, but ultimately preferred the term *close process attention*.

ommendation that under certain circumstances, the analyst should "change the focus of attention . . . from the id to the ego" (pp. 19-20). Following the observations of E. Kris (1938) and Sterba (1953), Gray (1982) elaborates this recommendation into a different mode of listening, suggesting that evenly hovering attention was always best suited to hearing the seductive call of the id, and is "no longer sufficient to satisfy the technical requirements of observing the silent activities of the ego" (Sterba 1953, p. 18), whose defensive activity we can only "reconstruct . . . in retrospect" (A. Freud 1936, p. 8), thus requiring a more deliberate focus.

Despite endorsements by E. Kris, Sterba, and Gray, it is not evident from a close reading of her text that Anna Freud meant to suggest an entirely different form of analytic listening, nor, certainly, to initiate as complete a revolution as Gray implies. Her aim was more modest, namely, that in analyzing what she called the "transference of defense," as opposed to the "transference of id impulses," the analyst should "change the focus of attention in the analysis, shifting it in the first place from the instinct to the specific mechanism of defense, i.e., from the id to the ego" (A. Freud 1936, pp. 18-20). This is in keeping with her well-known recommendation that the analyst direct

> . . . his attention equally and objectively to the unconscious elements in all three institutions. To put it another way, when he sets about the work of enlightenment, he takes his stand at a point equidistant from the id, the ego, and the superego.[5] [A. Freud 1936, p. 28]

[5] Before long, this precept had become the benchmark definition of analytic neutrality for ego psychologists (see, for example, Gray 1973, p. 478). Curiously, however, Anna Freud was not discussing neutrality at the time, nor does the term even appear in her monograph. As I have noted previously (Smith 1999):

> It would seem that ego psychology, seeking a more precise definition for a term loosely introduced in the topographic era, adopted Anna Freud's view of the analyst's attention to clarify a concept for which it was never intended. In other words, a precept without a name was grafted onto a term without a definition, and it then became the gold standard. [p. 470]

As one might study the changes on the surface of a body of water as signs of activity below (Levy and Inderbitzin 1990, p. 374), Gray casts "close process attention" as a way to examine the psychical surface for evidence of underlying ego activity. He compares his methodology to "apple sorting" (Gray 1991). Along the conveyor belt of the patient's associations comes one drive derivative after another, until there is a moment of conflictual interference to which the analyst can call the patient's attention.

While Gray (1986) makes clear that he is interested in an "optimum surface for interpretive interventions" (p. 253), note that in focusing on *surface*, he borrows a topographic metaphor of the mind. From a conceptual point of view, the surface becomes a transparent one, through which he can observe or infer the deeper structure and activity of the psyche, not unlike certain Kleinian descriptions of analytic process, wherein deep metapsychological structures seem to appear through the transparent surface of the clinical material. I hasten to emphasize that Gray's technical precept is precisely the opposite of what this analogy might imply, as he aims to stay with what is most immediately demonstrable to the patient.

While initially in agreement with Brenner on the fundamental nature of conflict as understood through what was then the standard view of the structural model, Gray's and Brenner's paths have diverged over the years. As we saw with Boesky and will see with A. Kris, Gray's focus on a methodological use of the patient's associations and on a redefined theory of technique leads him to a rather different view of the manifest architecture of conflict, including what we observe and where we observe it.

While Brenner would view every moment as a compromise formation with input from all the components of conflict, including at all times a mixture of erotic and aggressive wishes, Gray (2000), again with Kleinian analysts, places somewhat greater emphasis on the aggressive drive derivatives, especially with respect to superego analysis. Moreover, because he is looking for those moments of conflictual interference with the expression of drive derivatives, he emphasizes, by definition, the defensive com-

ponents of compromise formation, thus arriving at a position similar to Boesky's through a different technical and conceptual route. In sharp contrast with Boesky, however, Gray argues that his approach makes it unnecessary for the analyst to track his or her own associations or to follow the countertransference in the moment-to-moment work.

Compared to either Boesky or Brenner, there is a spatial difference in Gray's view of conflict. Conflict unfolds on the conveyor belt in front of him, as it were, not in the depths of the patient's mind. It is not that deeper determinants of conflict do not exist for Gray, but, like the particulars of countertransference, they do not need to be highlighted in the clinical moment. For Gray, this diminishes the size of the analyst's leaps of inference, as well as the tendency to reach past the patient's defenses. Interpretations are more likely to remain near the accessible surface for the patient, "in the neighborhood," as Busch (1992) has put it.

In summary, we might say that Gray, Boesky, and Brenner all agree on the effort to approach the patient in terms of what is immediately observable. Where they differ is in their methodology, including the nature and location of the conflict they observe (hence what they consider observable data to be) and the nature of the inferential and evidentiary process each employs.

The contrast between Gray and Brenner can be further highlighted by examining their separate objections to the concept of evenly hovering attention. Citing the innovations in Anna Freud's 1936 monograph, Gray sees close process attention as being in direct opposition to evenly hovering attention, and it is a skill that he explicitly teaches—not only to analysts, but also to patients. Brenner (2000) also cites Anna Freud's monograph in his own criticism of evenly hovering attention, but he argues that the position she espoused, rather than being an innovation, was most likely her father's position at the time as well. More specifically, Brenner does not emphasize Anna Freud's call for focused attention, but rather her description of the analyst's "equidistant" posture that I have cited above.

Brenner suggests that in Freud's 1925 statement of the analyst's listening, he, too, was beginning to discard evenly hovering attention in favor of listening to the "interplay between wish and defense" (Brenner 2000, p. 547). Thus, Freud (1925) wrote:

> If the resistance is slight he [the analyst] will be able from the patient's allusions to infer the unconscious material itself; or if the resistance is stronger he will be able to recognize its character from the associations, as they seem to become more remote from the topic in hand and will explain it to the patient. [p. 41]

While both Gray and Brenner would, I suspect, agree with this comment as it stands, they might implement the resulting inferential and explanatory processes rather differently. Note that Freud is speaking of two different inferential processes in the separate parts of this statement. While inferring the unconscious determinants of a resistance from the patient's "allusions" seems well suited to Brenner's approach, calling the patient's attention to a shift away from the "topic at hand" would seem to be an apt characterization of Gray's principal mode.

In passing, we might also contrast both Gray's and Brenner's views of evenly hovering attention with those of other conflict theorists, who still find the device to be a useful one. I am thinking here of Arlow's (1979) view of the limitless possibilities of the analyst's associations in the genesis of an interpretation, or Gardner's (1983) description of his own mind at work. While respectful of Gray's view of the focused observation of conflictual interference on the associative surface, Gardner (1991) demonstrates that "free attention," as he puts it (p. 865), including the drift of his own visual images, frequently leads him to useful representations of the defensive activities of the patient.

Behind the difference in Gray's and Brenner's methodological approaches to conflict lies a fundamental disagreement about the theory of mind. For a number of years, Brenner has held the concept of the conflict-free sphere of the ego (Hartmann 1964, p. x) to be a specious one, arguing that, as far as we can tell from

analytic data, there is no mental activity of any sort that is without conflict, nor any special region of the mind that is conflict-free. It is partly for this reason that Brenner shifted away from the three agencies of the mind, because they implied that the ego, or a part of the ego, was a conflict-free observer of mental activity.

But this view is at the very heart of Gray's analytic stance, as we can see from the title of his 1973 paper, "Psychoanalytic Technique and the Ego's Capacity for Observing Intrapsychic Activity." In an extension of Sterba's (1934) description of dissociation in the ego, Gray's argument rests on the ego's capacity to stand outside the conflictual sphere, enabling the analyst to form an alliance with the nonconflictual aspect of the patient's ego, to "draw that part of the ego over to his side" (Sterba [1934, p. 121]), and thus to teach the patient self-analytic skills. Brenner (1979), on the other hand, finds both the therapeutic alliance and self-analysis itself to be misleading concepts.

Gray is not alone in relying on aspects of psychic experience that are conflict free. We can find similar ideas in attachment theory, for example, in the concept of "secure attachments" and in the veridicality of the infant's perceptions on which that concept was founded. Even there, however, the notion of the veridical observer seems to be eroding, as attachment theorists begin to consider the individual variations in the way infants process external data, thus suggesting that reality may be registered differently—and hence in some sense altered—by each individual, starting with the earliest moments of ego development (Erreich 2000; Smith 2001a).

From a technical point of view, the differences between Gray's and Brenner's conceptualizations of conflict would seem to imply fundamental differences in both the content and process of what is analyzed. If Brenner's view of compromise formation encourages analysts to direct their attention to the various components of conflict and to choose the point of entry they imagine will be most fruitful and accessible, Gray's focus on the ego as the "center of clinical technique," in Busch's (1995) phrase, would

seem to encourage a more limited range of interventions, with the analyst's eye firmly fixed on the ego's capacity for observation and the defensive functions it initiates. We must, however, qualify any such inference. While it is true that the two theoretical approaches inevitably shift the analyst's attention in different ways, it would be as difficult to argue that Gray ignores the other components of conflict as it would be to insist that Brenner fails to account for defensive activity, or for what might be most accessible to the patient, when he frames an intervention.[6] Ultimately, how an analyst uses his or her theory is so critical and so idiosyncratic that it provides yet another argument for a more loosely coupled view of theory and practice, as I shall discuss below.

ANTON KRIS

In a series of papers outlining a methodology focused on encouraging the patient's freedom of associations throughout an analysis, A. Kris[7] (1982, 1984, 1985, 1988) distinguishes "two distinct patterns of conflict" (1985, p. 537), which he calls "convergent" and "divergent," according to their manifestation in the patient's material. Notice that as Boesky defines the intrapsychic domain operationally as a particular approach to the patient's free associations, and Gray outlines conflict in terms of the manifest surface of the patient's associations, Kris defines conflict in both manifest and operational terms: how the two forms of conflict appear in the patient's associations, given the analyst's particular use of the free associative method. Thus, we see once again that theoretical concepts such as *conflict* and *intrapsychic*, former-

[6] Note that many European analysts would see the entire North American love affair with the ego as an example of our having been led astray by ego psychology, and they would probably find evidence for it in the work of both Brenner and Gray. Their argument might be that appealing to what is consciously observable by the patient encourages a kind of intellectualization, and that the analyst's true focus needs to be on the deeper, unconscious processes, which the patient cannot know and hence needs the analyst to elucidate.

[7] For simplicity, Anton Kris will be referred to as Kris in the remainder of this paper. Note that Ernst Kris has been previously referred to as E. Kris.

ly defined rather narrowly with reference to the "interior" of the mind and its inferred contents, in contemporary work are frequently defined operationally in terms of the analyst's methodological approach to what is observable on the surface of the material. From this, it would seem not only that theory influences observation, but also that variations in technique alter the landmarks and definitions of theory.

Kris (1985) views convergent conflict as the traditional form of what he calls "conflicts of defense" (p. 537), in which the expression of an impulse is directly opposed by the ego. Here he retains the older conceptualization of conflict between an impulse and the ego with its mixed levels of abstraction. This view tends to reduce the nature of convergent conflict to a purely dyadic opposition, which Kris likens to a "play in football" (p. 538), in contrast to the more complex matrix of wishes, defenses, prohibitions, and painful affect in Brenner's view of compromise formation.

The divergent pattern, on the other hand, refers to "conflicts of ambivalence" (p. 537), wherein the components are paired opposites, such as love and hate, recognized in (but not limited to) the associations of the adolescent that typically alternate between "activity and passivity, homosexual and heterosexual, pregenital and genital sexuality, old objects and new ones, independence and dependence, autonomy and loss of self, self-control and dissipation, altruism and egotism, spontaneity and regulation, mind and body, fantasy and reality" (pp. 539-540). In divergent or ambivalent conflicts, each of these paired opposites "may at times be the subject of a sense of either-or, conscious or unconscious" (p. 540), as each pole pulls away from the other as in a "tug of war" (p. 538). Notice here that Kris's list of divergent conflicts includes paired items from almost every conceivable level of theoretical generalization, from the more specific (e.g., homosexual and heterosexual) to such broad categories as fantasy and reality or mind and body.

Recognizing divergent conflict, Kris suggests, encourages the analyst to allow the patient to resolve such conflict more

gradually through a particular type of mourning process—namely, the discovery that, as in mourning the loss of a person, one can still retain one pole of the conflict in fantasy if not in reality. In considering narcissistic and borderline patients, Kris argues that Kohut would not have needed to abandon the notion of conflict to the extent that he did, if he had recognized the importance of divergent conflict. Kris also suggests that if divergent conflict is not recognized in contemporary conflict theory, analysts will translate all conflict into convergent conflict, and, in a kind of methodological reductionism, will force premature closure by assuming that one of the poles is simply a defense against the other. Thus, Kris not only begins from a technical position—a particular use of the patient's associations—but also uses his view of conflict to underscore an important technical recommendation.

In comparison with Boesky's implicit disagreements with Brenner over the nature of conflicting wishes, Kris's disagreements are more explicit. As I note above, in Brenner's (1982) view, drive derivatives are never in conflict but can always be gratified sequentially or simultaneously with one exception, namely, when one wish is used to defend against another—as in the example of reaction formation, wherein loving wishes may defend against murderous ones. The essence of "ambivalence conflict," as Brenner calls it, is that "loving wishes are not merely gratifying as such. They also serve to defend against cruel, vengeful drive derivatives and vice versa" (p. 34).

While not arguing with Brenner directly, Kris (1984) takes exception to this position:

> I shall try to demonstrate . . . that it is not necessary—and is, in fact, incorrect—to assume that the tension between these pairs of opposites derives only from the repression of one of them in the service of the other. That is, not conflicts of defense alone but conflicts of ambivalence in conjunction with conflicts of defense account for the tension. [p. 219]

In so saying, Kris puts conflicts of ambivalence on the same playing field as conflicts of defense, as if the *conflicts* in convergent and divergent conflicts were in fact on the same level of abstraction. But is this so?

Notice here that Kris seems to be using the words *divergent* and *ambivalent* interchangeably, in which case *divergent conflict* becomes simply another term for ambivalence itself, broadly conceived, wherein the individual is drawn by two opposing aims, as in the adolescent's move toward independence at the same time that he or she is fearful about cutting parental ties. Kris (1984) disputes this: "I shall say at once that my term *conflicts of ambivalence* covers a much wider territory than . . . the term *ambivalence,*" and he does so by defining ambivalence narrowly as "affection and hostility directed toward the same object" (p. 215, italics in original; identical sentence in 1985, p. 539). Regardless of whether we think of them as evidence of ambivalence or of divergent conflict, however, large, conflicting aims, such as independence and dependence or spontaneity and regulation, are not on the same level of generalization as the conflicts between wishes, defenses, and self-punishments to which Kris compares them in his theoretical scheme. Unlike Boesky's effort to keep levels of abstraction distinct, Kris seems to be assuming that these different orders of conflict can be viewed from the same vantage point.

From a technical point of view, Kris's recommendation represents a clear break from Brenner's advice to listen to everything as compromise formation, for convergent conflict is merely a simplified version of compromise formation; whereas, as Kris sees it, divergent conflict is not. Note that each of Kris's divergent poles could be viewed as separate compromise formations in conflict with each other, pulling in opposite directions, if you like, with each made up of its separate component pieces, the wishes, defenses, self-punishments, and unpleasurable affects that shape them. In fact, unless one abandons the notion of compromise formation altogether, it is difficult to see how each pole would *not* ultimately revert to what Kris calls *convergent conflict,*

although this is precisely the outcome Kris is trying to forestall, and one to which, as he discovers, his colleagues inevitably seem to gravitate, including Anna Freud (Kris 1985, pp. 544-545).

Anna Freud speaks to this very point in response to a remark by Joseph Sandler (Sandler with A. Freud 1985). Sandler suggests:

> Perhaps one should comment that the ego has the capacity to reconcile opposing tendencies of the sort we have been talking about [e.g., homosexuality and heterosexuality, passivity and activity] quite readily were it not for such things as guilt. [p. 301]

Anna Freud replies:

> You know, it is easiest to show what happens with love and hate during the course of child development. You know how both tendencies can coexist in the beginning, before the synthetic function of the ego is there. Then you get a next stage when love and hate are still there, side by side, but the hate is objected to by the ego because to kill the loved object means that the loved object isn't there when you want it again. This is a low level conflict, but it comes to a higher level where the ego says that to hate any loved person is forbidden, that the love and hate are absolutely incompatible, not because of their outcome but because of their opposing nature. [Sandler with A. Freud 1985, p. 302]

In other words, in divergent conflicts, the conflict is not merely between general tendencies that pull in opposite directions, but more specifically, it includes the guilt that one tendency or the other may evoke, at which point we inevitably find ourselves once again in the realm of convergent conflict or compromise formation.

Although Kris (1984) disavows any interest in formulating his ideas in terms of a theory of mind (p. 222), in pitting one form of conflict against another at different levels of abstraction, he is in fact buttressing an important technical recommendation (in-

volving tact, timing, and the recognition of divergent pulls within the individual) with a modification of the conflictual model of the mind. In so doing, he may unnecessarily set himself in opposition to others, as he suggests Kohut did before him. We hear this when he speaks in terms familiar to us from the writings of some of our relational colleagues (see below): "So long as all conflict is viewed according to the paradigm of repression, with convergent opposition, the psychoanalytic situation is restricted, and the roles of its participants are sharply limited" (Kris 1984, p. 229). While not to leap prematurely at the interpretation of ambivalence seems more a matter of good judgment than theoretical correctness, one could argue that in order for the patient to begin to settle any divergent conflicts and to undergo the mourning process that Kris outlines so evocatively, convergent aspects of each pole of that conflict would eventually have to be analyzed.

The terms *convergent* and *divergent*, then, seem to be useful descriptives to denote different phenomena at different levels of organization. Just as it is necessary in Boesky's model to allow the analyst to view compromise formation through lenses of different focal lengths, not solely as competing wishes, so it may also be necessary to allow the analyst to consider both convergent and divergent aspects of all compromise formations. For if ambivalence itself is ubiquitous, it might be said that every compromise formation is made up of a mixture of divergent conflicts or ambivalent wishes—erotic and aggressive, loving and hating—the particular details of which would help define each specific compromise. If this is so, then Kris's technical advice would apply ubiquitously as well, even in Brenner's model.

THE RELATIONAL SCHOOL

I want to turn now to the role of conflict in the work of two psychoanalysts from different branches of the relational school, Philip Bromberg and Stuart Pizer, both of whom have made major contributions to the theory and technique of contemporary

psychoanalysis. I do not mean to suggest that Bromberg and Pizer speak for all relational analysts, who may constitute an even more diverse group than the conflict theorists we have been examining —with even less agreement on the role of conflict in analytic work. The relational school, both in its North American interpersonal roots and its more recent object relational affiliations, developed to a large extent in opposition to what was regarded as mainstream psychoanalysis in the United States (Mitchell 1997; Smith 2001b). On the one hand, we can hear the echo of these origins in the inevitable polarizations that result when relational analysts debate the role of conflict and propose alternative conceptualizations. On the other hand, relational analysts share so many continuities with the clinicians I have already discussed as to contradict the popular notion that the relational and conflictual groups are sharply distinct from one another. Rather, as we will see, they appear to form a continuum.

PHILIP BROMBERG

While there are similarities in the technical aims that both Kris and Bromberg espouse, Bromberg ties his view of technique, with its primary focus on dissociation, to a more radically redefined view of the mind, one that grants secondary status to the role of conflict altogether. In trying to elucidate Bromberg's view of conflict, I will draw on both his recent book (1998b) and two of his panel presentations (1998a, 2000).

We can trace Bromberg's interest in dissociation not only to Freud's early writings with Breuer, but also to Freud's later fascination with splits in the ego and the "side-by-side" (1927, p. 156) experiences that ensue, the same writings that initiated Kris's journeys as well. Even at the end of his life, Freud (1940) continued to wonder whether such configurations were "long familiar and obvious" or "new and puzzling" (p. 275). Through all of this, however, Freud did not pose them as alternative structures of the mind, as Bromberg does, nor propose that they lay outside of an underlying unconscious conflictual organization.

Bromberg bases his view of dissociation in part on Freud's (1923) description of "conflicts between the various identifications in which the ego comes apart" (pp. 30-31; Bromberg 1998b, pp. 132-133). If we put this quote in context, however, we find that Freud is describing here the structural development of the superego. Freud suggests that these splits in the ego are in fact an effort to deal with the intensity of the "drives." In other words, such dissociations are part of an unconscious—convergent, if you will—conflictual organization. Bromberg, on the other hand, writes of "areas of personality that are organized by conflict . . . interwoven with areas organized by trauma" (1998b, p. 258), and speaks of "certain phases of *all* treatment" when "we are in fact dealing not with conflict, but rather with a broad range of dissociated states" (p. 216, italics in original).

Over the past several decades, Bromberg has carefully integrated many aspects of more traditional theory and technique into the interpersonal model in which he was trained. When he poses a dichotomy between dissociation and conflict, however, or more particularly, between dissociation and repression, he seems to be arguing with Freud's earliest model, one in which repression was the only recognized defense.

Bromberg (1998b) attributes Freud's purported neglect of dissociation to the observation that Freud "abandoned his recognition that trauma exists as a reality in shaping personality . . . and turned exclusively to the concepts of psychic reality, fantasy, and internal conflict" (p. 215), thereby "[dismissing] the phenomenon of dissociation" (p. 226). As I read him, however, Freud (1939) never in fact abandoned trauma as a reality, but to the end of his life maintained that trauma might in theory result either from terrible external events or from a highly fragile temperament, and that in real life, what we invariably see are combinations of the two factors, the internal and the external, forming what he called a "complemental series" (p. 73), the psychic registration of trauma being the final common pathway. We can see here the distinction between Freud's model, in which trauma, dissociation, and conflict are woven into a single view of the mind, and Bromberg's, in

which dissociation and conflict each maintain a place as separate organizing principles and appear sequentially both in development and over the course of an analysis. Thus, Bromberg (1998b) posits a "structural shift from dissociation to conflict" (p. 283) and advocates that "part of the work in any analysis . . . is to facilitate a transition from dissociation to conflict" (p. 275).

More recently, Bromberg (2000) suggests that in a typical analysis, there is a shift from "a mental structure in which self-narratives . . . are organized primarily dissociatively" to one in which they "will be able to engage one another conflictually." Here we might ask what exactly the conflict of self-narratives looks like. What is the conflict about, where is it, and what motivates it? Once again, we encounter a conception of conflict at a very different level of generalization, but one not necessarily incompatible with the other views we have been examining.

Bromberg says that thinking of the dissociative organization of the mind helps him to stay with the patient's current state—not to overlook one self-state or another, nor to value one at the expense of another—and here, too, we note the similarity with Kris's technical position. But once again, it is not clear why Bromberg's technical recommendations need to be buttressed by a new theory of mind.

As I have suggested in the introduction to this issue (Smith 2003) and elsewhere (Smith 1997, 1999, in press), such arguments seem to reflect a subtle conflation of theory and practice. Because every theory of mind and every view of the role of conflict tend to push our habits of practice subtly in certain directions, while steering us judiciously away from others, such conflations are not unusual. They are reinforced when patients comply with our approach, and so we come to believe that they are confirming our theory of mind as well as our habits of practice. But, as the plethora of current approaches testifies, it is possible to think of other ways of staying with the patient's current state without positing a supraordinate position for dissociation, and it may be misleading, therefore, for Bromberg to link his theory of mind so closely with his discipline of practice.

I am arguing here, as earlier, for a looser coupling of theory and practice than we are generally taught in our institutes. This habit of mind is promoted in our literature by those who would support their technical recommendations with theories of mind to make it look as though the practice followed necessarily from the theory, rather than, more loosely, the other way around.[8]

The question in Bromberg's case is whether we are talking about different organizations of mind or different ways to address the patient. Bromberg (2000) says, "Because the patient is spared being in the constant position of feeling he is being asked to trade off certain of his realities, the experience of 'wholeness,' rather than some external definition of 'cure,' is achieved." Here I would ask, while we can see the various positions against which Bromberg is arguing, how many analysts of any persuasion still speak of "curing" a patient? Bromberg adds, "Since there isn't just one narrative to start with, there isn't a different 'one' to end with"—but again, is there ever just one for any of us? On this latter point, Bromberg's approach may indeed help us to find all the different places the patient inhabits, but we could say the same for conflict theory. Neither theory ensures such an outcome. It all depends on how it is practiced.

From the point of view of conflict theory, in fact, one might argue that the very activity of dissociation, at the moment it appears in the clinical hour, is itself a compromise formation and could be analyzed as such; or that each self-state held dissociatively apart, like Kris's divergent conflicts, is made up of various compromise formations, the component parts of which might need to be analyzed in order to bring such self-states into "conflict" with each other, as Bromberg suggests, toward establishing an experience of "wholeness."

I believe that Bromberg is correct that we have underestimated the role of dissociation in the organization of the mind, and I would agree that it may be a neglected and ubiquitous feature

[8] Fonagy (2003) reaches a similar conclusion through a somewhat different route in his contribution to this issue.

of our patients' mental lives, but I have some difficulty with his way of explaining it. When he says, for example, "Freud's conception of a dynamic motivational system is in an ongoing dialectic with a complex latticework of psychic structure, one central organizing principle of which is dissociation" (Bromberg 2000), I do not understand how a motivational system and a structure can be in a dialectic with each other, except perhaps in the analyst's theoretical model.

I would like to suggest that one can observe in the patient's mind evidence of conflict and evidence of dissociation, but that the two are part of a single developmental process, separable only in the mind of the analyst, not in the life of the patient. To pit one against the other, I believe, not only removes aspects of the patient's experience from the realm of analyzable conflict, but in various ways limits the reach of the work. Such a division of labor stands in sharp contrast to a view expressed by Anna Freud (1974). In speaking of two types of infantile psychopathology, one "based on conflict" and the other "based on developmental defects," she wrote, "However different in origin the two types of psychopathology are, in the clinical picture they are totally intertwined, a fact which accounts for their usually being treated as one" (pp. 70-71; quoted in Boesky 1988, p. 132).

We hear Bromberg's polarizations when he speaks of organizing his thoughts about the patient around the idea of self-states *rather* than defenses, or intervening from a stance that is inherently experience near *rather* than interpretive, or attending to the structural implications of the material *rather* than its intrapsychic meaning, or focusing on perception *rather* than ideas. These polarities are reminiscent of Kris's (1984) suggestion that divergent conflict stands in opposition to the "paradigm of repression" (p. 229). Each polarity oversimplifies the complexity of the situation, a complexity Bromberg is trying to capture in his metaphor of the dialectic, now hammered into a more linear movement from dissociation to conflict, rather than one in which the elements are commingled.

Based on his descriptions of his own clinical work, I am convinced that Bromberg is working with unconscious conflict in the

lives of his patients. They seem to be filled with the same anxieties, depressive affects, wishes, defenses, and self-punitive trends as are Brenner's, Boesky's, Kris's, or Gray's, but it is not entirely clear what Bromberg's idea of unconscious conflict is.

One of the underlying problems is that Bromberg tends to conflate *conscious* conflict and *unconscious* conflict. Because this reflects a common confusion in contemporary theory and practice, I will try to spell it out. When Bromberg (1998b) speaks, for example, of the patient whose "dissociative mental organization was beginning to shift and she was starting to experience conflict around issues that had been simply enacted . . ." (p. 220), or says that for certain patients, "the experience of internal conflict is only remotely and briefly possible" (p. 183), he is suggesting—correctly, I think—that dissociation minimizes, or is incompatible with, the painful psychic experience of conflict. Here he is speaking of *conscious conflict* in the way we do when we say that a patient is incapable of tolerating the experience of ambivalence.

But when Bromberg (1998b) tells of the patient who is "incapable . . . of the experience of intrapsychic conflict" (p. 204), or speaks of "the period of therapeutic transition from dissociation to the subjective experience of intrapsychic conflict and ambivalence" (p. 326), his terminology is confusing. Intrapsychic conflict, to my understanding, denotes *unconscious conflict*—conflict traditionally between the three agencies of the mind, for example. It is an inference about what organizes the mind and underlies a patient's experience, including, some would say, the experience of dissociation. To speak of a "subjective experience of intrapsychic conflict" is, to me, a contradiction in terms. Ambivalence can be a conscious, subjective experience; intrapsychic conflict is always an inference about the unconscious determinants of such experience. Once again, they represent different levels of abstraction. Here Bromberg seems to be talking about the patient's ability to sustain a state of conflict, like a state of ambivalence, thereby holding two or more conflicting motives or feelings in mind at the same time. This is a conflic-

tual process, but a largely conscious one that we expect to see emerge as patients become stronger, more able to manage their own affective states.

In my experience, while dissociation may help prevent the patient from experiencing *conscious* conflict, it appears to me to be not separate from, but an integral part of, a largely *unconscious* conflictual organization—a defense against intolerable affect, for example, including traumatic affect and the ideas associated with it. In this regard, it may be fruitful, as with Kris's view of ambivalence and divergence, to think of dissociation and disavowal as a part of every conflictual structure, including every defensive or adaptive maneuver.

STUART PIZER

For a second look at a relational view of conflict, we might briefly examine Pizer's (1998) work, in which he argues for the consideration of paradox as a mental phenomenon separate from conflict. Pizer views conflict as an *either-or* way of seeing things, while paradox poses a *both-and* situation (p. 151). Thus, "conflict can be resolved," whereas "negotiation of paradox yields not resolution but a straddling, or bridging, of contradictory perspectives" (p. 65).

I am fully in support of Pizer's view of the paradoxical elements in human experience, both generally and in mental phenomena in particular. These ubiquitous paradoxes bear considerable resemblance to the divergences, ambivalences, and dissociations that Kris and Bromberg highlight as well; but in describing paradox as irresolvable, Pizer adopts a term that is frequently used to characterize a contemporary view of conflict. To suggest that paradox must be tolerated, whereas conflict can be resolved, is to polarize the two in such a way that Pizer ends up, in effect, shadowboxing with an anachronism. This anachronism, in fact, is one of Brenner's (1994a) fundamental disagreements with traditional structural theory:

> According to structural theory . . . the goal of treatment is the resolution of conflict . . . . conflict is supposed to disappear . . . . Since the fact is, however, that conflict over what were originally pathogenic drive derivatives is still obvious and still active in the mind of every patient who by all other criteria has made substantial analytic progress, the structural theory is clearly not adequate . . . [pp. 478-479]

I. Hoffman (1998) restores the historical context to Pizer's argument when he writes, "There is a bridge from Freud to postmodern moral uncertainty, since the structure of Freud's thought encourages consideration of multiple sources of conflict with no clear basis for their resolution" (p. 7), a statement that would support the paradoxical nature of conflict itself. Hoffman goes on to suggest that Freud's view of the irreducible nature of conflict is a precursor of the current interest in the "decentered self" (p. 7), as represented, in Hoffman's view, by Mitchell, Bromberg, and Pizer, among others.

That the distinction Pizer (1998) is drawing between paradox and conflict may be more artificial than real is further implied when he writes, "Parties negotiate not because they are in conflict, but because they are in a condition of *both* conflict *and* interdependence. I think of this as *the paradox of conflict"* (p. 178, italics in original). If we were to translate this example from the social domain to the intrapsychic one, it would describe precisely the interdependence of the components of intrapsychic conflict and their paradoxical state in every analysis, where the voices of wish, defense, self-punishment, and unpleasurable affect are each allowed to speak and are never fully reconciled.

Pizer's effort to elevate paradox to a central position in the theory of mind functions in the service of an important technical position, similar to that espoused by Kris and Bromberg: namely, that the analyst must allow for simultaneous or sequential expression of different facets of a patient's experience at all levels, conscious and unconscious, and for the simultaneous ap-

preciation of both the analyst's and the patient's experience. In the course of doing so, the analyst will inevitably encounter incompatibilities and paradoxes, the components of which exist side by side (as Freud once put it), are "divergent" (in Kris's term), and hence for the moment are irresolvable. It would seem, then, that Pizer, too, is highlighting a fundamental aspect of mind and of the nature of conflict as it is lived.

CONCLUSION

The effort to marginalize the role of conflict in mental life is more prevalent today than it once was. Although conceived somewhat differently, conflict, according to Greenberg and Mitchell (1983), was very much at the heart of the work of earlier relational theorists:

> Sullivan, Fromm, and Horney all portray the human experience as fraught with deep, intense passions. The *content* of these passions and conflicts, however, is not understood to derive from drive pressure and regulation, but from shifting and competing configurations composed of relations between the self and others, real and imagined. [p. 80, italics in original]

Similarly, they write:

> In Fairbairn's model, all the major protagonists in internal struggles are essentially relational units, composed of a portion of the ego and a portion of the child's relations to the parents, experienced as an internal object. Conflict takes place among these three ego-object components (libidinal ego/exciting object; antilibidinal ego/rejecting object; central ego ideal object). [p. 167]

In addition to the specifically tripartite nature of Fairbairn's view of conflict, I would note that what Greenberg and Mitchell are here making explicit had been an implicit part of Freud's theory at least as early as the 1895 Project—namely, that all the

inner agencies develop in relation to the objects in a child's world. This position is still seen in Brenner's view of the components of compromise, all of which have objects as their aim and at their origin. (See also L. Hoffman 1999.) As Cooper (2000) puts it, every conflict is "inextricably bound to internalized relational patterning."

We can hear Mitchell's (1997) own view of conflict, based on "conflictual relational configurations" (p. 221), in his reflections on his analysis of a patient named Andrew.

> Eventually, it helped me to learn about the early history of his sense that to choose his father was to lose his mother forever, and that to choose his mother was to lose his father forever, and that to choose to love them meant to lose any satisfactions in living, and that to choose to enjoy life meant losing them and his childhood forever. [1997, pp. 162-163]

I would suggest that not only could this eloquent passage be used to illustrate Kris's view of divergent conflict, but also, despite Mitchell's (1997) stated opposition to Brenner's position, he seems to be working quite compatibly with what Brenner calls the miseries of childhood that result from conflictual wishes and fears, the defenses we develop against them, and the punishments we inflict on ourselves as a result.

Why this tendency, then, to disavow or redefine the importance of conflict among contemporary relational analysts and others? Does it represent a marginalization of the past (Smith 2001b)? Or a reaction to what Pizer (1998) has called the "hegemonic language of conflict" (p. 167), with its implicit reminder of many decades of traumatic exclusion? It is rare these days to hear analysts speak about analyzing the sexual and aggressive conflicts of childhood, but not so rare to see evidence of it in their work. As Pizer's term *hegemonic* suggests, might the phrase *sexual and aggressive conflicts of childhood* be so politically tinged that it can no longer be spoken? Or interpreted in so limited a fashion—artificially linked, perhaps, to an archaic view of drive

theory—that we cannot acknowledge the childhood wishes it denotes? Despite much of our contemporary rhetoric, do we secretly believe it impossible to attend to both intrapsychic and relational data simultaneously?

Because psychic conflict can be inferred and described at every level of abstraction and generalization, I suggest that we could take any piece of clinical material and examine the conflict inherent in it in each of the ways outlined in this paper, with no fundamental contradiction or incompatibility. In this regard, another look at Waelder's (1962) description of the levels of psychoanalytic thinking may help illustrate what I have in mind. In Waelder's schema,[9] starting with the level of clinical *observation*, there follows the clinical *interpretation* of those observations, and then the level of clinical *generalization*, where we gather together data into larger concepts, leading next to clinical *theory*. These are the levels within which most of us work clinically. Beyond them, Waelder envisioned the more abstract domains of metapsychology and philosophy.

Notice that within the first three levels, there are no real incompatibilities in the approaches we have been studying. At any given moment when, at the level of *observation*, there is a shift in the patient's associations, for example, Brenner might notice a change in the prevailing compromise formation, Boesky might infer the interaction of conflicting wishes, and Gray might perceive an instance of conflictual interference. At the same moment, Kris might infer the operation of a divergent conflict, Bromberg the transition from one self-state to another, and Pizer the ongoing negotiation of a paradox. These all represent different *interpretations* of a single clinical observation. They are shaped by higher levels of theory. They may call for different choices as to how to intervene. But they are not in themselves incompatible. They are *complementary interpretations of the data*, reflecting the fact that many things are going on at the same time

[9] I have discussed these schema more fully in the introduction to this issue (Smith 2003) and elsewhere (Smith 2001b, in press).

and can be pictured simultaneously at different degrees of generalization.

I suggest that, if we do not leap too quickly to the level of clinical theory and beyond, we might discover many compatibilities in both the observations we make and our interpretations of them, despite the unfamiliar terminologies that we would be forced to entertain. If we bear in mind that, when examined in enough detail, Kris's divergent conflicts can be seen to break down into convergent ones, and that the components of divergent conflict exist in somewhat separate states, not unlike the dissociated states that Bromberg describes, might it be that every patient experiences many more or less separate "self-states"—each existing side by side, each with its own "internalized relational patterning" and its own set of compromise formations that sustain it and keep it, to some degree, dissociated from the others?

You can hear my bias that the theory of conflict and compromise is flexible enough to include relational, interpersonal, and dissociative points of view within its purview, if we do not falsely polarize them. In this regard, it might be useful to consider the following points: *(1) conflict is ubiquitous and can be described at every level of a person's experience, from the most specific intrapsychic focus to the broadest, most general, and most abstract of inferences; (2) there are different methods of observing, describing, and analyzing conflict, some of which have been falsely tied to specific theoretical positions; (3) just as we can describe conflict at different levels of abstraction, we also inevitably listen to it at different levels of abstraction in the consulting room, each level corresponding to a different aspect of the patient's conflictual experience; and (4) many theorists who would emphasize alternatives to conflict theory may be speaking of aspects of experience that are not mutually exclusive from, but may quite compatibly exist within, a conflictual view of the mind at different levels of generalization.*

I hope that this effort to outline some of our many conceptions of conflict and the bearing they have on psychoanalytic technique, both inside and outside of the group we identify as con-

flict theorists, will help to illuminate some of the confusions we share in contemporary psychoanalytic discourse and some of the similarities and differences in our contemporary views of analytic work.

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SPATIAL METAPHORS OF THE MIND

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A case in which the author began to understand her patient as "collapsing the space between them," rather than as continuing only to free associate, is the occasion for a contemplation of the way psychoanalytic theory effects a transition between what is inner, or lived, and outer, or experienced. Metaphor is seen as the agent of this transition. The author discusses metaphor in relation to the case described, while also examining spatial metaphors of mind in classical analysis and in Kleinian theory. It is suggested that both may be integrated in a third metaphorical-spatial construct, Green's analytic space.

CLINICAL MATERIAL – I

As Professor H lay down on the couch for his first analytic session, he gestured toward my desk, with its somewhat disorderly evidence of work in progress, and in an imperious and dismissive tone, said: "You really ought to put up a screen there." Not too much later in the analysis, Professor H mentioned that he had slept in an alcove next to his parents' bedroom. As evidence accumulated, it was not surprising to find that looking away had been a prominent defense, and not difficult to suppose that Professor H had prescribed a reproduction of the very doors that had closed out everything and yet nothing.

This patient's transference was characterized by acute but unacknowledged depressive reactions to cancellations, weekend

separations, and vacations. He gradually became aware of resentment and vindictiveness toward me, but never of any underlying positive attachment that might have provided an underpinning for his feeling of betrayal. He described childhood rescue fantasies in which a woman, ill treated by men, picked him out of a crowd and recognized his devotion. He resented that I did not respond adequately to his attempts to get me to admire him. Nevertheless, he felt intense jealousy when he read that I was giving a course with a male colleague. He rationalized and isolated this reaction, and was embarrassed to feel its accuracy when I made the connection. He feared his father and covered over the fear with contempt and loathing. Eventually, his associations opened upon very direct primal scene material related both to the transference and to his childhood.

Professor H's associations, together with occasional enactments, led to our understanding of his wish to be his analyst/mother's one and only, a sense of her betrayal by being with his father (my work, family, or a colleague), the narcissistic injury of being excluded from the parental couple, murderous wishes for vengeance toward both parents, envy of his father for being stronger and better equipped, longing for his father to lend him strength, and hatred of his analyst/mother and of all women because they always disappointed him by proving to be impure. His associations, my interventions, and his related responses enlarged the scope of this understanding, leading to explicit, heretofore repressed childhood memories. His shock, castration anxiety, rage, felt betrayal by his mother/analyst, wish for vengeance, sense of his inadequacy as a male, and envy of and longing to acquire power from his father/analyst all emerged feelingly.

Something fundamental remained immovable, however. Professor H continued to react with painful symptoms to changes in the schedule that he took as slights, to be unaware of any positive attachment to me, and to enjoy subtly this failure as a vengeance. Insights into the past and his relationships with primary objects were used more as a means of diminishing my importance than as a pathway to insight and change. Although his work, which

he had at best performed pro forma, became a significant source of accomplishment, pleasure, and satisfaction for him, his object relationships remained unrewarding. He played a significant, caring, and considerate paternal role with three young nieces, the daughters of his widowed younger sister. Otherwise, he stayed in a bleak, unsatisfying, mutually vengeful relationship, continued to behave in unacknowledged, often quite subtly vindictive ways toward me, and was generally isolated. If his associations to my interventions seemed to carry the work farther in individual sessions, he remained passive in his attitude toward the material he provided, and more often than not completely forgot the insights arrived at.

Realizing the need to reexamine my understanding of Professor H and of the work we were doing together, I began to scrutinize my subjective states when with him. Although routine, a reassessment of this nature is, in fact, complex. The literature has emphasized the sequence through which self-analysis leads to new insight and results in changes in one's understanding of a patient. Such a sequence appropriately privileges the analyst's conflicted contribution to stalemate. Indeed, it would be quite possible to identify equivalent countertransferential forces in me. However, there is a less recognized aspect of the process of reassessment, one certainly also connected to countertransference, but in a far less direct fashion, and it is this aspect that I wish to discuss in this paper.

What I have in mind is the analyst's change, during the process of reassessment, in what I shall call *metaphors of transition.* In paying attention to what I was feeling, I was *imaginatively reorienting my position in space, as the analyst vis-à-vis the patient, from a position where I was an outside interpreter of a transference involving me to one where I was the recipient of a communication inside me.* That is, *I was changing the metaphor that provided the imagery not only for our places in relation to each other in space, but in the form and manner of Professor H's communication with me.* Through it, I sought to gain better imaginative access to that aspect of Professor H's inner life unknown to him, as well as to the unknown aspect of

my own inner life that was responding to what I could not see in his.

Spatial metaphors of the mind of this nature are often distillations of theories of mental functioning that directly affect technique. It makes a difference both in how one listens and how one talks to a patient whether one imagines oneself as the outside observer of a transference fantasy involving oneself, or as a participant in it, for instance. Although we often think about the kind of shift I have described as a change in theoretical orientation, sometimes a shift in the use of metaphor may represent an expansion of one's use of the original theory beyond its metaphorical constraints. Thus, while the type of opening up I refer to may well represent a working through of a countertransference that had allowed the analyst to become imaginatively imprisoned by the dominant metaphors of a particular theory, it may just as well represent a working through of a transference to a particular teacher who stands for a way of thinking clinically, and whose theoretical position has consequently become invested with the mantle of authority.

In either case, metaphors are crucial to the way theories function in the clinical setting. They play a central role because of the nature of psychoanalytic theories of the functioning of the mind. Despite our tendency to think of these theories as relatively objective constructs, psychoanalytic theories are best conceived of as transitions between inner, or what is lived, and outer, or what can be observed and expressed. These two categories, as Green (1975) has pointed out, represent the poles between which the work of psychoanalysis must occur. I shall rely on them in what follows.

THEORY, TRANSITION, AND METAPHOR

The idea of a psychoanalytic theory of the mind having a transitional function will seem alien to most of us, despite the knowledge that the subjectivity that theories of the mind's functioning attempt to account for cannot be arrived at by exclusive reliance

on externally observable phenomena, and that there exists a divide between what is observable and therefore capable of being described, and what is lived and thus only very partially and approximately observable and communicable. That divide must be crossed by the conjectures that make up a particular theory. Analogously, psychoanalysis, as a treatment method, requires its practitioners to cross the divide within themselves between inner and outer, known and unknown, with regularity, and to encourage patients to become adept in the same way. We imagine not only that part of ourselves that is only vaguely apprehended, but also that aspect of the patient's mind that we need help grasping. We use imagination, together with a method of listening, to put ourselves in the place of our patients in order to understand what they experience, and sometimes also to articulate that experience.

If the result of imagination in clinical analysis is the analyst's and patient's halting and piecemeal articulation of a difficult-to-apprehend part of the latter's experience, and the complex reasons that comprise it, the distillation of analogous imagination in articulated theory is the metaphor. Although related to analogy, metaphor does not explicitly recognize its analogical origin. Instead, it crosses over disparate categories and combines them in ways that surprise. Love is not *like* a red rose, it *is* one, and the mind *is* deep, a space to be plumbed. Metaphor creates in language an illusory space between two categories in which the categories are neither one nor the other, but both and neither. That illusory space suggests an analogy to Winnicott's (1951, 1971) idea of transitional space.

Metaphor becomes the vehicle that links what we intuit but can barely verbalize with what we can perceive and know. It is essential for the work of the mind that studies itself—given the limitations and paradox that the fact of the mind's studying itself entails—to posit and to have this illusory transitional space for imagination that metaphor provides.

Frequently, the poetic affinities of metaphor have made it an unpopular vehicle for the expression of theory. Far from disap-

pearing, however, metaphor has generally become implicit. Here is a passage from a paper by Winnicott (1945) on primitive emotional development:

> There are long stretches of time in a normal infant's life in which a baby does not mind whether he is in many bits or one whole being, or whether he lives in his mother's face or in his whole body, provided that from time to time he comes together and feels something. [p. 150]

Despite Winnicott's writing as though he had access to the inner experience of an infant, most people who read this passage in context do not seem to care that the author cannot possibly ascertain what the infant external to himself experiences (Ogden 2001). Winnicott has just been discussing the patient who fills his first session of the week with the details of every hour of the time spent without the analyst on the weekend, and concludes that the patient may need "to be known in all his bits and pieces by one person, the analyst" (1945, p. 150). At this moment of his text, Winnicott invokes "the ordinary stuff of infant life" (p. 150), and describes the unintegrated state in the way it appears above. As Ogden (2001) has argued in discussing this passage at length, the analyst of the patient who exhaustively recites his or her weekend activities may be tempted, out of impotence and anger, to make a resistance interpretation, even if the analyst's clinical sense is that the patient is doing something adaptive. Winnicott's accomplishment is to link the patient's behavior with the object's role in providing an integrating experience, so that the analyst has a theoretical reason to continue to listen rather than to act out of frustration.

But it is how Winnicott makes this link that is of particular interest. In his general explication of his conception of an infantile unintegrated state that is a basis for later regressive disintegration, he moves back and forth between his imaginative recreation of infantile development and his clinical experience, so that the two become fused in our consciousness, and it is difficult to say which informs which. At the moment in his text of

imaginative encounter with the frustrating patient, it appears natural that Winnicott reaches out for a baby. The authoritative statements about the infant's subjective state that follow do not strike us as impossible to know, *because we read them as metaphors for the patient who spends an entire session describing the time spent without the analyst.*

To be sure, there is a double direction in Winnicott's paper: on one side, it points to the metaphorical, experiential view that I am emphasizing; on the other, to the more concrete developmental perspective (albeit with a minimalist timetable and a focus on inner process, not external events) that is manifestly asserted. But this very double direction exemplifies and illuminates the transitional function of psychoanalytic theory in the subtle encompassing, without denomination, of metaphorical/subjective and developmental/objective positions.

Thinking of theory, through the work of metaphor, as creating a transition between outer and inner invokes once again the analogy of transitional objects and phenomena (Winnicott 1951, 1971). As Roussillon (1999) has observed, Winnicott's contribution is a theory about the psychological coming into being of the mind. To focus on how the mind uses theory in clinical work is to focus on an analogous process: how our understanding of what has heretofore been inner and unknown, in ourselves and/or in another, comes into being as something conscious. Of course, there is an inherent circularity in a theory about the mind's functioning being used to characterize the way our minds use a theory about the way our minds function, but this circularity is inevitable, a variation on the paradox of which Freud made us aware by articulating the existence of the unconscious: since the mental functioning we attempt to explain occurs partly beyond our conscious awareness, we study the unknown dimensions of the mind with the very instrument composed of unknown dimensions beyond our knowledge.

Although we are more familiar with psychoanalytic theories that are presented as though "obliged to maintain a 'scientific' distance from their object of analysis" (Roussillon 1999, p. 11, my

translation), it is more accurate to think of them as transitions between outer and inner, and more useful to assess their value partly by whether they help us cross a similar divide in ourselves in the process of doing clinical work. Constructing theory as though it were objective truth limits it, as well as obscuring its transitional function. For example, in a seminal paper by Isaacs (1943) that set out the Kleinian position on fantasy during the controversial discussions at the British Society (Reed and Baudry 1997, p. 472), the role of transition is shifted away from theory through equivocation. Fantasy, Isaacs said, was both "the psychic representative of instinct" (Isaacs 1943, p. 277) and "the subjective interpretation of experience" (p. 282). Fantasy as the mental embodiment of instinct is fantasy conceived as a wholly inner event, which is then objectified as structure. Fantasy as the interpretation of experience is fantasy as subjective transformation of external reality. Although the definitions are different, Isaacs treats them as equivalent, and in that way, the concept of fantasy, with its two *different* definitions that are treated as equivalents, becomes the vehicle of transition. Theory then mistakenly appears *not* to be transition, but as definitively *describing* an inner transition.

Brenner (2000), to choose a psychoanalytic theoretician whose careful argumentation more closely reflects contemporary concerns with the methodology of evidence, names the sources of his data, labels the conclusions resulting in his clearly articulated version of conflict theory as conjectures, proceeds to reason according to the laws of logic, and insists that his inferences not contradict established facts in neighboring fields. However, he presents data from religious myths to support conclusions (originally based on adult psychoanalyses) concerning early childhood sexual and aggressive impulses. Although these data may have undergone significant transformations from childhood origins, he does not take into account the possibility or nature of these transformations, nor does he acknowledge that those transformations might undermine the data he uses to establish the nature of early childhood conflict. The transitionality of the theory is buried in the neglected transformations that the data have undergone.

There is a direct correspondence between the objective vision of theory shared by Brenner and Isaacs and the content of the theories they formulate. Following Freud and Klein, both hypothesize theory that minimizes the variable contribution of specific, material reality to individual psychic reality, instead emphasizing universal psychodynamic, intrapsychic processes (Green 2000).[1] This emphasis leads to formulations of self-sustaining systems. For instance, in Freud, the drive is toward the object representation of the drive cathexis, that is, toward something already represented within and then refound. In Klein, the object representation is governed by prewired fantasy that includes internal objects, so that the relation to the primary object is already a transference. Both theories thus assume that what is unconscious can be retrieved because it is already represented, whether buried within the mind or projected into another.

A theory that more explicitly takes into account the intersubjective, circumstantial quality of the object relation, as well as its intrapsychic consequences, may also take into account the possibility that qualities of the object—a psychotic mother, to take an extreme instance—could lead to a failure of representation, to an intrapsychic state in which an object is either eternally and intrusively present or decathected and missing (Green 1975). That is, such a theory reorients the analyst toward thinking about the potential relation of subject to object as that relation is shaped, but not dominated, by the drive derivatives. A reorientation of this nature encourages us to focus substantively on the process of symbolization, the many gradations between the presence of the object and its ultimate representation, and the pathology associated with different outcomes of the process. That is, it leads us to focus on the processes of *transition from presence to symbolized ab-*

[1] I am here emphasizing the focus of the theories. Practice is another matter. Because patients teach us to look beyond the blinders that theories might impose, we learn to take into account what is crucial, and in so doing collectively correct theoretical emphases. Practitioners of either theory would surely argue that specific circumstances of material reality are not overlooked in practice, and indeed, that theoretical provision for them exists.

sence. It is these very processes that are required of a body of theory that must bridge what is lived and what can be expressed. I will return to this issue when I discuss the concept of analytic space. The point here is that the insistence on theory as objective entity rather than as transitional function may restrict the potential scope and complexity of theoretical formulations that ought to account for fragmentation, faulty symbolization, and experiences of nothingness, as well as of hidden presence (Green 1998).

No matter how careful our conjectural process or how certain our theory, theory ultimately traverses a chasm from that which is observed to that which is inferred about the inner life of a subject who is other than we, or other than the part of us that is conscious. Evaluations of the basis on which the leap from observation to inference occurs aside, the vehicle of choice to carry us over a chasm not unlike Pascal's void is metaphor. Moreover, one might say that for a practicing clinician who must hourly bridge the gap between abstract theory and the challenges and mysteries of work with a (not the) patient, the imaginative transition afforded by metaphor is a necessity.

Although theories restrict the metaphors available to us, they also provide us with the means to make transitions through the richness of the metaphors they do furnish. The metaphor links disparate worlds: conscious expression and unconscious fantasy (Arlow 1979), lived and verbalized experience, the states of different subjects. Through it, the patient may become an infant for us in the very way love becomes a rose. That is, our experience, real or imagined, of holding a squalling baby and trying to calm it has to do with our hope that the baby will recognize a state of protection and calm connected to us, and it is this experience that we summon both to the metaphor and to the clinical situation it attempts to clarify. Metaphor, visible or invisible, is the transitional mechanism par excellence.

SPATIAL METAPHORS OF THE MIND

Metaphors inherent in specific theories exert a powerful influence on the way we use theories, as well as on the way we think about

how we use them. For the sake of this paper, I shall restrict myself to metaphors of space that evoke both a concept of the psyche and of the relationship that is possible between analyst and analysand, and I will limit myself to a consideration of spatial metaphor associated with (a) the classical or conflict model, (b) the Kleinian model of the paranoid/schizoid position, and (c) that elaborated by Green (1975). Depending partly on the theory, mental space can be imagined to be:

(a) largely contained within the borders of the mind of the individual, and including a buried portion that the analysis uncovers through the transference. The boundary between analyst and patient is established and largely intact, and there is an equivalent boundary between the analyst as transference fantasy inside the mind of the patient, and the analyst as materially real without;

(b) dispersed among self and object and within parts of self and parts of objects, so that parts of self and object are rearranged and reassigned in terms of what is unwanted and what is desired. A boundary-providing function is required of the analyst because the mental space of the patient and the space in which the relation between analyst and patient takes place may become congruent and fused, and may need to be separated;

(c) dispersed in relation to a maternal/analyst surround that is seen as belonging neither to one nor the other, but as a mutual space of facilitation, potential, and creativity. This transitional space comes into being as an analytic space in which communication occurs, and representation, if it has been heretofore compromised, is now possible.

The analyst imaginatively saturated with spatial metaphors, both implied and explicit, will conceive of him/herself, the patient, and their respective roles in arriving at a cure congruently

with what the metaphors evoke. My work with Professor H is telling in this regard.

CLINICAL MATERIAL – II

Once I began to focus on my reactions to incidents like Professor H's opening instructions on redecorating my office, I realized that I always felt taken aback, invaded, dispossessed, inadequate, and sometimes righteously angry. Contemplating retrospectively the incident I have described, for instance, it struck me that I was experiencing Professor H as asserting a dictatorship of design, wiping me out as a separate person with a taste of my own. This realization freed me from being so like Professor H that I was sharing his tendency to look away and refuse to see things that led to painful feelings. I was able to see clearly for the first time that there had been no room for difference between him and me. *I began to imagine that he had collapsed the space between us.*

To speak of the space collapsed between us is actually to invoke the absence of two kinds of space. One is that needed to maintain the "as ifness" of the transference, where the image of the analyst saturated with, say, negative feeling may be held at the same time as the different image of the analyst as analyst. The other is the space that allowed a difference between us as individual subjects. In recognizing the absence of a space for difference between us, I was reestablishing it in my own mind. The transference, I began to see, was not one Professor H could join me in observing from without. Moreover, it was much less triadic than dyadic. That is, if one were to think from my new perspective about the primal scene that had been such a focus of our work, it would be in terms of the existence of only an omnipotent subject and a degraded object, the two being undifferentiated. Each figure was, through his narcissistic identifications, an unintegrated aspect of Professor H.

What I had seen as a well-delineated, structured, oedipal triangle, in which my work represented an object of more value to me than he, was reorganizing itself in my understanding to

become a condensed scene of projected and introjected "bits and pieces" of the patient himself. In it, once he found himself thwarted in his wish for a narcissistic union with me, his mother/analyst, he took on a sadistic and omniscient omnipotence, a parody of the paternal authority he did not genuinely have, and evoked in me (or projected into me) that part of himself identified with the helplessness and inadequacy of the child-onlooker as it was condensed with the victimhood, powerlessness, and degradation of the mother/whore. I had unwittingly been joining him in the actualization of this scene.

As a result of my imagining a different spatial relationship between us, I also saw that Professor H's words at these charged moments could not be treated entirely as associations. They were also acts asserting his omnipotent control of me. My feeling of being invaded became a significant piece of data, an immediate affective communication from him to me that signaled his attempt to control me. It existed on a plane different from that of word patterns we could contemplate together. In avoiding cognizance of this invasion, I had been identified with Professor H's omnipotent canceling out of the difference between us. In assuming his capacity to join me in deducing the unconscious content concealed and presented by his associations, I was overestimating his capacity for differentiated functioning in a way that complemented his inflation of himself. Now, instead of assuming that he possessed this capacity reliably, I began to recognize the subtle way in which his use of free association was a successful attempt at getting me to admire him by creating in me a good feeling about my ability to interpret his unconscious fantasies.

Emphasis on the data of what I was feeling with Professor H led me further to recognize that he could not always be spoken to as if he had an integrated ego. His collapsing the difference between us so that I felt taken over, invaded, and possessed meant that he was destroying the contact between us as separate individuals and evoking in me feelings that corresponded to aspects of himself that he wished either to incorporate or

to get rid of. I was not the neutral observer of his transference to me. I was a receptacle for denied or wished-for aspects of himself, and unconscious aspects of *my* self were facilitating these introjective and projective processes.

I began to see also that the patient's tender feelings for his nieces were a central expression of a disavowed part of himself. These feelings could only be expressed toward them because he could expel his frightening dependence on me by locating it outside of him in these children, in a relationship where his little nieces were dependent on him. At the same time, he could be helpful and understanding to them in a way he experienced that I was to him, without acknowledging in any way that he experienced me as helpful or understanding, let alone that he needed me to be that way. Caretaking and being taken care of were other ways, besides being admired by an admired object, by which he could secretly re-create a state between us that was without boundary.

These new perceptions enabled me to change my interpretative tack and to focus on Professor H's lack of differentiation from me, first as it appeared in the mental state wherein he achieved admiration. His feeling of being admired by me and his lack of differentiation were both aspects of himself that, in the normal course of our analytic work together, were silent and successfully masked, but that emerged in moments such as during his first hour on the couch, with a suddenness that I always experienced as shocking. I gradually learned that the moments in which he reacted like this were moments in which he himself experienced a shock, one that undermined a persistent defensive fantasy. In it, he and I were an amalgamated and omnipotent unit. Either he was my admired part or I was his. No wonder, then, that unanticipated cancellations on my part led to massive hostile reactions. These reactions occurred when he experienced me as acting independently, eliciting in response the devastated other side of his grandiosity. He then attempted to get even by some often-subtle maneuver—a request for a change of appointment, for instance, which, if agreed to by me, reassured him about his special status and ability to control me.

After much focus on the patient's wish to be one powerful entity with me, he began to recognize and talk about his shame and sense of inadequacy. He discovered how he used women whom he perceived as powerful. By making them into extensions of himself, he protected himself from paralyzing anxiety. He began to see that he felt this anxiety when he had to do something on his own. He forgot the work we did less often.

Work on a dream during this period illustrates some of this new psychic movement. The context was his receipt of my bill reflecting a larger, previously agreed-upon fee. He began by mentioning that he had become exhausted and unable to face paying his bills the night before, and awoke with a painful physical symptom. Although he gave no indication of realizing it, this symptom usually accompanied unrecognized depressive states connected to the transference. The dream he had had, he remarked, had "nothing to do with" his eagerness to pay me the new fee and his inability to stay awake long enough to write out the check. I intervened to suggest that he might be asserting this irrelevance to protect himself from painful feelings connected to my having asked for an increase in the fee. He continued by describing his dream. In it, he had to fix the muffler on his car. The muffler was unusually constructed. "There was a small screw, shaped like a V, like a set screw. It screwed into the larger screw in a very beautiful way. When screwed in, it was completely flush —a very nice piece of engineering, but the small screw had been lost."

In his associations, Professor H noted the sexual references, waiting for me to pick up on them, and then, when I did not, he began to speak about the "pleasure and excitement" of observing how "this tiny screw goes into the larger screw, perfectly flush." The muffler and a big engine had fallen down under the car. "They were all held in place by this little screw." As he spoke, his exaggerated wonder, pleasure in the beauty and engineering of this device, and admiration for it were palpable. I could feel his intense, almost manic excitement. I became aware of momentarily sharing it, not as admiration for the engineering, but as admiration for a dream image exactly representing his wished-for

union with me. I suggested that the little screw perfectly flush inside the bigger screw, controlling everything, holding everything together, depicted the relationship he sought with me—indeed, the one he was seeking with me now, in which I would be so carried away by admiration for him that we would both feel enhanced and together.

He returned to his having "shut down" the night before. He had not then connected his mood to his feelings about my bill, but he did so now. He then remembered a dream in which he could not be forceful in a group of adolescent girls because his voice was weak. Some of these girls were very excitable and excited. Something about women who were very emotional frightened him. I connected his feeling of helplessness and inhibition to his disappointment in me. He believed my raising the fee showed that I was indifferent to him. I might get excited, but then I dropped him, and he felt frightened by his disappointment in and consequent rage toward me. Being dropped was the opposite of the feeling he had when imagining the two flush screws together. If he were together with me in the way he wanted, he would not feel anxious at being with excitable and exciting women.

He had just been thinking about his difficulty being alone, Professor H continued. The previous night, he had been alone while paying his bills. It was like something he had recently talked about with me: his not wanting to go alone after the session to a new place to meet someone he did not know. "I wanted to be with someone to take away my anxiety, to take care of me . . . . It sounds strange, being angry because someone doesn't do these things for me." He talked about the fact that, as a child, he had felt as though the women in the house were his servants, and how he still wanted to be treated that way.

I suggested that Professor H wanted me to be an extension of him so that he could be sure that I did whatever he needed me to do, so that he would not feel anxious and on his own. "There's a lot of evidence for that in how I have run my life," he responded. He continued that he felt the pain from his symptom, but not

the resentment he must be harboring for not getting his way. He would feel protected if he could control me in the way he wanted to. I said it would spare him the anxiety he felt when he was on his own, but that he had always needed to wear a mask with people because he was ashamed that he felt so anxious. After a brief pause, he reported that the pain had disappeared. He said the fact that the muffler fell in the dream meant that it was defective. There was some confusion about the car, and there was something wrong with him; he could not hold it up. He realized that the previous day, he had avoided taking the initiative with a woman in whom he was interested. He hoped he would have another opportunity.

To return to the metaphors that initially influenced my understanding of and technical approach to Professor H, without my being aware of it, I at first imagined the patient and me as inhabiting separate spheres that intersected at the point of communication. To facilitate that communication, I might cross briefly into Professor H's sphere, but only enough to make a trial identification, that is, to sample his subjective state (Beres and Arlow 1974). I imagined Professor H's mind as a self-contained, more or less accessible whole, in which the least accessible unconscious parts could be understood by virtue of his associations and affective reactions, particularly as they involved fantasies about me.

In the second version, however, I imagined the space between us as collapsed so that we were each inside the other's mind. Minds in this image were not self-contained but dispersed, unintegrated, and intermingled, so that parts of each could be interchanged. That is, in a more abstract formulation, contact between us as differentiated individuals had been replaced by narcissistic exchanges of unintegrated internalizations and externalizations. This second version, clearly closer to the explicit spatial metaphors that make up a Kleinian description of the paranoid schizoid position (Caper 1999; Klein 1946), was more conscious than the first.

Classical theory is expressed more extensively by abstract concepts. Thus, although metaphors function as transitions to the patient's inner state, channeling aspects of the analyst's imagination, they tend to go unnoticed. In these metaphors, the mind is evoked imaginatively in the way I first imagined Professor H's, as self-contained and as concealing significant elements buried in its depths (Freud 1937, p. 259). The neurotic model at the base of this theorizing emphasizes intactness. One "speaks to *the* ego" in interpreting anxiety before impulse. If there is a flaw in the functioning of the superego, it is not that the superego is in pieces, but that there are lacunae in an agency otherwise assumed to be whole. Intactness brings with it the idea of delineated boundaries among spaces, and thus between the minds of selves and objects.[2] There is a clear distinction between the transferential analyst *within* the transference neurosis (that is, within the patient's mind), whose presence is to be interpreted, and the materially real analyst *without* who does the interpreting (Reed 1994, 2001).

This spatial conception gives rise to ideas of a therapeutic split and therapeutic alliance, and influenced my initial assumptions about Professor H's capacity reliably and consistently to observe himself. Both the therapeutic split and the alliance are based on the capacity to be connected to and differentiated from the object, and are very different from a defensive split in a narcissistic organization, which I came to understand was the state of affairs with Professor H.

The primacy afforded the drives draws attention to their exigencies in the space between their matrix in the subject and their

[2] The transference neurosis, Freud (1914) wrote, was "an intermediate region between fantasy and real life," something enclosed, a "playground," accessible to interpretation from outside itself by the materially real analyst (p. 154). The analyst within its boundaries was a version of the patient's fantasy, to be dissolved, along with the transference neurosis itself, by interpretation of the contained fantasies (Reed 1994). Despite a similarity of lexicon, this intermediate region, with its definite boundaries between fantasy and reality, self and other, is very different from Winnicott's transitional space of indistinct ownership, its me/not me fluidity, its material and purposefully metaphoric fuzziness.

revelation by objects.[3] This emphasis minimizes the subject/object poles where the interface with material reality occurs, and thus channels attention away from the quality of a particular object's interactions with a particular subject. In addition, any potential fragmentation or lack of integration in the related agencies or objects tends to be relegated to a place of secondary importance. As Arlow (1980) points out, the concept of part object makes no sense because the object is whatever the drive seeks out for its satisfaction, whether a whole person or a part of a person, since the object is always the object representation of the drive cathexis, whatever its quality. In the analysis of Professor H, I tended to concentrate on conflict beginning with the drive derivative, and my attention was in this way diverted from the divided state of the patient's ego.

Given the power of unrecognized metaphor to influence our thinking, the psyche that emerges as our imaginative default is thus a space extending in depth and containing significant content to be uncovered, only unrecognized traces of which are initially available. In the version more connected to the structural theory than the topographic, integrated, discernibly whole agencies—id, ego, and superego—interact and conflict with each other by means of drives arising from the depth of the id, and executed and/or defended against by aspects of the ego. This rather closed intrapsychic space also contains a deep unconscious to be uncovered, though it is parceled out between the id (the drives) and the ego (the seat of memory and fantasy). In both versions, the conflicts that occur within are capable of being observed from without. Indeed, the analyst as archeologist is first and foremost an observer/detective, expected to remain separate from that version of him- or herself that is located within the patient's transference as fantasy.

[3] I use the term *subject,* following Green (2000), to denote that which is the opposite of object, a composite referring to the series of terms such as *self* and *ego,* in both their conscious and unconscious dimensions. Just as there is no one object, but rather a multiplicity of objects, there is no one subject.

Because there is an assumption that the patient has an intact ego, the data used for interpretation are the verbal derivatives of the drives (or their equivalents in action), as these have combined with ego activities, memory, wish, defense, and childhood understanding or distortion into a network of unconscious fantasy/memory constellations. With this image of a closed, integrated, and delineated mental space in our minds, we listen to the derivatives as products of that mind and seek to make its workings intelligible to that aspect of the patient's ego that is allied with the working analyst and able to grasp its own incongruities.[4] With Professor H, I assumed a degree of differentiation in line with these expectations. The power of these metaphors works against distinguishing between an effective mask (Kernberg 1984) and a healthy adaptation.

To be sure, this image of the mind is not required by the theory, and neither, therefore, were my assumptions dictated by it. Freud's (1927, 1938) formulation of perverse conflict solution, or of intrasystemic conflict, for example (Rangell 1963), Jacobson's (e.g., 1954) formulations on the self and the object world, and Kernberg's (1975, 1984) synthesis and expansion of conflict theory to encompass object relations theory all expand our imaginative horizons. These formulations include the potential for conflict solutions that differ in their power to create structural *discontinuity* from compromise formations of a neurotic nature. Laplanche and Pontalis (1967) emphasize the phenomenon of discontinuity by describing the splitting of the ego as comprised of two separate defensive solutions, one based on neurotic mechanisms utilizing repression, the other on psychotic mechanisms utilizing denial. Such a formulation brings us to a universe in which the patient is indeed divided, and individual agencies are not intact.

[4] Given a patient more obviously compromised in his or her integration, I suspect that these metaphors of space lead to a clinical tendency that Nasir Ilahi (2001) has noticed: to wait silently, or to make only supportive interventions, in the expectation that the patient will be "reborn" as an integrated individual in the oedipal phase.

However, such formulations tend to run counter to the dominant metaphors that we, as members of an analytic group, ascribe to an authoritative theory and that then influence the technique we employ (Grossman 1995, Reed 1994). At the imaginative visual level, the metaphoric undertow pulls our imagination toward the conceptualization of integrated entities that interact by virtue of the predominant drive energies. Operating within the imaginative universe provided by this theory and reinforced by the authority we unconsciously ascribe to it, we tend to speak to a patient in conflict in a way that assumes that he or she is capable of experiencing both sides of the conflict at the same time, and of containing it. This idea is not the totality of the theory so much as it is *the intuitive and unrecognized byproduct of the way we imagine the theory working through specific metaphor to create the necessary transition between inner and outer.* Together with transference, such a metaphorical level may function to narrow existing options when creative divergence is most necessary. In the case of Professor H, my overestimation of his capacity to be both separate and connected was an aspect of the admiration he sought, so that there was a fit between his defensive needs and the way my countertransference availed itself of theory.

Far different from the space of classical analysis is that metaphorical space in which the multiple processes of projective identification occur—that is, Klein's paranoid-schizoid universe. There space tends to extend horizontally, as parts of the self cross into the other and parts of the idealized other are assimilated into the self. The unit of delineation here is also the individual psyche, but a psyche in "bits and pieces," to use Winnicott's phrase. The theory posits a potential whole self and a whole other, but treats them as readily dispersible, its parts interchangeable. It assumes a partial self that utilizes an other that it distorts. Space must therefore include this distorted and cannibalized self or parts of selves and complementary other, or parts of other.

Moreover, given this imaginative rendering, the analyst occupies the space with the patient, and is the recipient of projected and introjected aspects of the patient's self. This movement of

parts of the self into the other and vice versa becomes a major, nonverbal means of communication that either supplements or replaces the verbal derivatives of drives that are free associations. This communication can take place because of the greater fluidity and lack of separation between working and transferential analyst, analyst and patient. The therapeutic analyst contains the projections of the analysand, and in so doing, helps the patient to integrate split-off parts of him- or herself.

Three major differences from classical evocation result from the differences in images, implied or described. First, there is an emphasis on the state of the executor and recipient of the drives. Subject and object are seen as interacting through the agency of the drives, with the latter in the background and the former in the foreground. Thus, whether the ego and its object(s) are in an integrated or unintegrated state at any given moment becomes an important and immediate clinical concern. The object, however, remains a product of preexisting fantasy, so that every relation to a materially real object is a transference.

Second, there is a change in how the spatial relationship between analyst and patient is conceived. Just as the ego and object can be integrated or unintegrated, so the object and subject of analysis—and therefore also the transference and countertransference—are potentially less separate and separable. That is, the emphasis is less on the boundaries between the analyst and the patient than on the frequency with which those boundaries may be crossed and on the therapeutic need to sort out parts of self and object in order to reestablish boundaries through the containing function of the analyst. One might say, in spatial terms, that the analyst and patient are situated differently vis-à-vis each other than is the case in a classical or conflict model. Rather than the materially real analyst's observation of the fate of a fantasy about him- or herself within the patient's transference, we must account for a materially real analyst's discovery of elements of the patient within him- or herself, with a possible loss of elements of that self within the patient.

Third, there is a concomitant change in the conception of what constitutes analytic data, because the image of parts of the

self crossing over into the other and influencing that other leads directly to the valorizing of nonverbal subjective states in the analyst. Verbal derivatives are no longer a sufficient, or even the primary, source of information about the patient. When they are used, they are taken to refer to mental states of the subject in relation to the transference object.

THE ANALYTIC SPACE

The shift of working metaphor I have described accompanies psychic reorganization in the analyst, helping to foster it by enlarging the metaphoric universe through which transitions from the analyst's understanding of the more remote reaches of him- or herself to those of the patient are effected. We may conceptualize this enlargement as part of the process of communication when patient and analyst are working (that is, struggling) well together. Such communication has the potential to transcend the metaphoric constrictions inherent in the analyst's theory. The subjective transformation in the analyst seems best expressed not by speaking of a change of theory, but by a third set of spatial metaphors that unifies the two previous approaches. These can be found in Green's (1975) concept of analytic space that draws on Freud, Winnicott, and Bion. Winnicott's (1945) phrase about the baby not minding for long stretches of time "whether he is in many bits or whether he lives in his mother's face or in his own body" (p. 150) evokes the ambiguity of the interplay between an unintegrated self and the maternal surround. The conjunction, assuming adequate mothering, creates a space of potential and facilitation.

Similarly, the effort of the analyst to understand the analyst's self with the patient, and through the understanding of what is alien in that self, to come to an understanding of what is other in the patient, and the effort by the patient to put as much of what he or she experiences into words that convey both the known and unknown portions of the patient's self—these factors together create a complex intertwining of doubles consisting of what each

party "lives and what they communicate" that is a "potential space," the analytic session, where shared metaphor becomes possible (Green 1975, p. 12). Although this entwining set of doubles has been made popular through Ogden's (1994) term, the *analytic third,* I believe that Ogden overemphasizes the subjective factor at the expense of the intrapsychic. My reading of Green, particularly in a recent clarification of the topic (Green 2000), is that he emphasizes a continuing dialectic between the intersubjective and the intrapsychic.

This metaphorical analytic space belongs neither to analyst nor patient, but is the creation of their profound communication and thus of each of them together. It may be seen as analogous to the transitional object of the infant that "*is not an internal object* (which is a mental concept)—it is a possession. Yet it is not (for the infant) an external object either" (Winnicott 1971, p. 237, italics in original). There is already in Winnicott a complex interaction between inner and outer. For the transitional object to exist for the infant, adequate provision of care from the external object is required. Otherwise, the internal object becomes too persecutory, "fails to have meaning for the infant . . . and the transitional object becomes meaningless too" (p. 237). That is, the structure and integration of the inner world depend on the interrelation between external care and internal dynamics.

The analytic space is also a place of intersection, but in Green's conceptualization, what comprises that intersection is a complex interaction between intersubjective and intrapsychic for both patient and analyst. The particularities of the patient's objects and his or her ensuing degree of representation of them intersect with and influence the dynamic internal interplay among drives and subject, in a way that affects the analyst not only intersubjectively but also intrapsychically. It is here that the patient's ability or inability to symbolize the object as absent could become a crucial issue of treatment, because the degree of representation of which the patient is capable affects both the patient's thinking and the degree of integration of the ego and the object representations. If an object has been too intrusive, it is impossi-

ble to represent it and thus to conceive of its absence. If the object, as a result of its unavailability, has been too idealized, it may remain impossible to connect with (Green 1975). In either case, a persecutory object may be held onto to ward off the threat of nothingness and emptiness (Green 1993), and the analyst is kept excluded in a position of impotence and empty-headedness. Under these destructive circumstances, the analytic space will not evolve.

The analytic space has a frame analogous to the mother's arms (Green 1997). Mutable and living, it is created by the gradual articulation of the affects and conflicts that arise within the setting for analyst and patient, which they together pursue, though in different ways and toward different ends. The relationship between them provides the context out of which meaning emerges. The general movement in the creation of the analytic space is toward a discrimination of what is inner and alien in oneself and what belongs to the other.

The metaphorical space between analyst and patient here is one in which a gap between them (between what is lived in the patient and communicated, and what is lived with the patient in the analyst and communicated as understanding) is transformed into a space of communication that is neither that of one mind nor the other. Rather, it is a space that provides the context in which meaning between analyst and patient can exist. The analyst must be able to use his or her capacity both for self-understanding and for understanding the patient to reach the communication in the material given him by the patient, "as well as gauging the possible effect, across this gap, of what he, in return, can communicate to the patient" (Green 1975, p. 5). To create this space and transform the gap, the analyst has to offer him- or herself first as a narcissistic object, what Green (2000) has called a "similar other":

> I subordinate all access to the otherness of the other, as other, to the existence of . . . another person who is similar enough to be able to identify with him or her and

> thus be of assistance to that person in his or her . . . helplessness. [p. 19]

That is, one does not assume a degree of separation (difference) of self from object, either in the sense of the self as alienated from its unconscious, or as it is capable of enough integration to symbolize the absence of the object.

> Difference of the other as different (either intrapsychically the other insofar as he or she is unconscious; or intersubjectively, the other insofar as he or she is an ego outside of oneself) is both a development of the similar other or an opening toward a new destination: that which is similar is no longer so. It is other. I can imagine it, for I no longer need the support provided by my similitude. Consciousness of being separated from the other no longer threatens my position as an ego. [Green 2000, p. 19]

With a growing sense of communication and understanding about what is alien in the self and in the other comes a growing delineation of boundaries between self and other. The intrapsychic here duplicates the intersubjective. One gets to know the alienated parts of the self through the similar other.

Where psychic structure is not severely impaired, the construction of an analytic space may be barely discernible, and attention may be quickly focused instead on the conflicts that deploy themselves within it. Yet even there, as was the case with Professor H, the concept clarifies the phenomenon of the analyst's change of thinking about his or her patient that might otherwise be ascribed to a change of theory. Where psychic structure *is* impaired, the construction of the analytic space takes primacy of place because that very construction facilitates new structure. Given Green's conception of non-neurotic patients as suffering the dual and competing anxieties of separation from and intrusion of the primary object, making it impossible to symbolize the object in its absence, this idea of a mutual space also allows for an intermediate relation that is neither intrusive

nor separate. Data derive from both internal subjective states in the analyst and from the patient's associations. The analysis of non-neurotic patients will depend more on the former, because it relies on the hazardous enterprise of induction, as Green remarks (1975, p. 5). And that implies the scrutiny by the analyst of his/her own subjective state and contributions to the patient's reaction. The analysis of neurosis, on the other hand, requires primarily that one listen to the patient's associations and deduce from them the unconscious fantasies.

DISCUSSION

It is possible in these terms to understand the shift in metaphors that allowed me to make the transition between Professor H's subjectivity and my own—not as a shift from one theory to another arising from a recognition of error, as I have provisionally described it, but as *part of a larger inductive analytic process. In this process, the transition from outer to inner and from conscious to unconscious, as well as the establishment of the space in which these transitions occur, takes place very gradually.* For Professor H and me, this process included as a first stage the enactment between us, given who we each were and what we were trying to do together.

At the beginning of this process, Professor H did not admit the need for treatment, but characteristically availed himself of outside circumstances. Nevertheless, he also let me know indirectly quite soon about his problems in relationships, his anxieties, his difficulty taking initiative, his proclivity for being hurt. He was both unconsciously communicating his inner pain to me and working very hard to pretend that it did not exist. Moreover, this need to conceal who he thought he was and what he felt went to the most profound roots of his character. Charming and personable, he used these gifts to stay distant without at all seeming to. His was not a performance in the usual sense of the term. His life was a performance: to seem normal when he did not feel himself to be so.

I was both taken in by his performance and, by the very nature of the analytic compact, not taken in, since I was attempting

to hear what he indirectly told me about his inner pain. From the start, then, there was a division in me that reflected the division in him, and prevented me from seeing that the apparently collaborating, reasonable person on the couch was not someone reasonably willing to work on identified "problems." His division was such that one side disavowed his awareness of difficulties while the other side was painfully aware of them. Although I early began to interpret his tendency to look away, and gradually became aware of his forgetting previous work (particularly that in which we together established conflicts that caused him pain), I tended to think about him as someone who used disavowal as a defense against certain conflicts, but who was otherwise fairly consistently aware of his difficulties. I tended to treat the side that was aware as all of him.

If my doing so led me unwittingly to participate in a mutually admiring narcissistic enactment, that participation can also be seen as necessary to the analytic work. It respected Professor H's fragile adaptation, sparing him premature mortification and alleviating his anxiety over being different from me by the temporary reinforcement of his illusory omnipotence. At the same time, it established the preconditions for the creation of an analytic space. That is, despite my theory-syntonic efforts to do otherwise, I began by participating in an enactment in which I was similar to Professor H. The goal of my inner work would be gradually to become similarly *other*, to differentiate myself enough to communicate my understanding of what was happening and had happened between us and why.

From this point of view, and from a point of view that excludes my unconscious intuition, quite ironically, the implied metaphors dominant in the conflict model influenced my technique in a way that facilitated Professor H's staging of a performance and my participation in it. The performance both prevented either of us from discovering too quickly what lay beneath, and provided us with a baseline of experiences that could ultimately be transformed from the manifest performance into what it concealed. For example, when breaches in the hidden strength

he derived from me occasionally became apparent—with the appearance of his unacknowledged depressions and painful symptoms around separations, for instance—the contempt with which he met my interpretations about his loss of me allowed the subject to be broached, while he both "saved face" and revealed important genetic data by reversing roles. It gradually emerged that he was showing me the contempt he felt for himself for having feelings—only girls had feelings—and that he had originally experienced from his parents and siblings toward himself.

I do not mean to imply that the metaphors inherent in the conflict model directly influenced my technique so as to create the performance. Rather, they influenced my technique in an unintended manner that served both Professor H's intrapsychic needs and our intersubjective ones. Without them, and given a different analyst, some other way would have been needed and found to do the same thing.

In retrospect, from the perspective of the creation of an analytic space, my reassessment of my approach to Professor H was a step in an already ongoing process. I had become conscious of a slight frustration that gradually metamorphosed into the sense of a block inside myself, the affective representation of the split-off part of Professor H to which I was not listening, and that undermined the work leading to his owning his inner difficulties. The attempt to reassess, the shift of working metaphors, and the ensuing reorientation and change of interpretative tack seem to me best seen as my ways of integrating this new awareness in myself. They were all part of my growing comprehension of Professor H, which emerged as the analytic space became gradually more established and elaborated, which in turn facilitated its further establishment and elaboration.

CONCLUSION

The view of theory as transitional is directly related to the idea of a transitional analytic space, where what the patient lives but cannot directly articulate can gradually be put into words through

the analyst's communication of his/her understanding, and where the analyst's simultaneous inner transitional work allows this understanding to occur. Theory that helps the analyst make the transition between what he/she experiences and what he/she begins to grasp consciously, first in him/herself and then in the patient, interacts with the analyst as though it were the analyst's benign surround. Just as the analyst's articulated understanding functions to contain or hold the more disturbed, fragmented patient, so well-functioning metaphors of transition work to hold the analyst at difficult or obscure junctures of the analytic work, uniting disparate clinical experiences with the patient and unarticulated intuitions arising from these and other life experiences (real and imagined) with an apparently more abstract explanation. The new understanding then enables the clinician to feel support for a strong intuition, instead of being caught in a conflict where what feels right clinically seems to involve going against the tenets of the theory.

Metaphor embedded in theory thus facilitates the creation of the analytic space. I do not mean, of course, that any idea makes a valid theory, only that how we use theory in the clinical situation and what the theory provides for us as clinicians go beyond the manifest content of a given theory to its form (and what that form evokes in us). Evaluation of a theory needs to include an assessment of the way and degree to which it facilitates our ability to make the transition between inner and outer.

Psychoanalytic theory has not generally been considered from the perspective of its transitionality. Rather, it has been taken as a "consensually validated view of reality, shared by a number of people, having an independent status *so far as the individual is concerned*" (Grossman 1995, p. 890, italics in original). This only partly conscious way of viewing theory allows free rein for development of the more insidious, unconscious meaning of theory as authority, and for the act of applying it as a submission to authority—a meaning that influences the form of many current controversies, often overshadowing the specific clinical context.

In contrast, the concept of a transitional analytic space created through the subjective interactions and understanding of patient and analyst provides a larger and more inclusive context for what happens between them. Because it is mutable and evolving, it emphasizes process and is far less likely to encourage the turning of technical guideline into behavioral rule.

By virtue of this greater integration, the type of "error" in which I engaged, a transient misapplication of theory that was an adaptive enactment, may be seen as the very stuff of the analysis of transference. Thus, "error" becomes data. Indeed, there is a refocusing from "error" to the particular clinical context in which it occurs, so that what is important is the meaning of the action in the context of a particular analyst–patient interrelationship. Although the mode through which analyst and patient at first communicate (or better still, miscommunicate) undoubtedly serves the latter's adaptation as well as the former's conflicts, that mode is also the material out of which the analytic space is forged.

Especially with more disturbed patients, the concept of the analytic space has technical consequences. Interventions may be chosen to foster the transitional process and thus the construction of the analytic space. For example, where there is a lack of differentiation, interpretative interventions may introduce difference between self and object, but only gradually, through the mediation of the inevitably already established narcissistic transference object, whether one calls this transference object a part object, a selfobject, or a similar other. On the one hand, such a technique avoids the intrusion that occurs with many interpretations that assume the patient is differentiated when he/she is not, or that proceed to interpret the lack of differentiation from the point of view of the differentiated analyst rather than the undifferentiated patient. On the other hand, the treatment does not stop with the establishment of a narcissistic transference, but proceeds to the analysis of this transference. Differentiation and the exploration of the intrapsychic that differentiation makes possible remain the treatment goals.

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IN SEARCH OF THE ELUSIVE NATURE OF CLINICAL PSYCHOANALYTIC THEORY

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Two case vignettes illustrating different ways of listening to clinical material are presented. The author discusses some limitations of clinical psychoanalytic theory that stem from the fact that primary unconscious processes are, by their very nature, impossible to describe in a language regulated by secondary processes. Hegelian dialectics, first addressed in psychoanalysis by Lacan and later elaborated in the work of Green, as well as the use of paradox by Winnicott and the formalistic approaches of Matte Blanco and Bion, are briefly reviewed as alternative formulas. As psychoanalysts, we are condemned to live with doubt, and neither clinical theories nor metapsychology offer escape from this reality.

> For things are often spoke and seldom meant
> But that my heart accordeth with my tongue.
> —Shakespeare, *Henry VI, Part II,* III, 1, 268-269

INTRODUCTION

Clinical theory occupies a problematic place in psychoanalysis. The roots of the word *clinical* (from the Greek *kliniké*, meaning medical practice at the sickbed, from *kliné*, the bed) lie in the doctor's care of the patient and in the priest's administration of

last rites.[1] Observation in medicine, in that sense, is remote and different from that used in our field. Psychoanalytic clinicians are not attentive observers at the foot of the bed. Our conception of *clinical fact* differs considerably from the medical one, and indeed, even from the psychiatric one. Listening to the patient's free associations[2] with an evenly hovering attention, submitted to the transference and countertransference as presented in the intersubjective and intrapsychic spheres, is an entirely different proposition. What we purport to understand and interpret is inevitably tied to subjectivity, and furthermore, to the complex and contradictory characteristics of unconscious processes.

To elucidate all the problems posed by clinical theory in psychoanalysis exceeds the scope of this paper. This would require a background of epistemological discussion into which I do not wish to enter. I will, therefore, limit myself to a presentation of the difficulties posed by the use of theory in everyday clinical practice, and will attempt to illustrate these by presenting two short case histories. These do not pretend to be exceptional, and aspire only to portray some of the difficulties that I perceive. As to my personal perspective, it is far from original, even if it may seem alien to mainstream American psychoanalysis. It is, of course, subject to a controversy which is inherent, unavoidable, and—in my opinion—healthy for our task.

THE CASE OF MR. A

Mr. A, then twenty-six years old, consulted me while in a state of deep depression and anxiety. He was subsequently seen on the couch in a traditional, four-times-per-week analysis. Of swarthy complexion and average height, he was a highly intelligent anthropologist who maintained a consistent commitment to the process of his analysis.

[1] The most complete review of the development of the clinical point of view is found in Foucault (1963).

[2] This is not, by the way, the most accurate translation of *freie Einfälle,* because of the latter's associative connotations, historically linked to psychology.

The patient related that, while working in a remote city in the south of Perú, he suffered from an uncontrollable urge to seek out prostitutes and transvestites. After these episodes, he felt extremely guilty. He had a long-standing relationship with a woman of his age, highly intelligent and attractive, and they had lived together for some years. Lately, sex had become unsatisfactory, and he accused her of avoiding him. He stated that this was in marked contrast to the initial stages of the relationship, when sex had been very gratifying. What emerged was that when Mr. A felt anxious or depressed, he would demand that his girlfriend perform fellatio on him, after which he frequently left her. Though the relationship was now a disaster, he decided early in the analysis to marry her. I felt this to be a clear case of acting out, in that he needed to create a bond with his girlfriend in order to protect himself from the homosexual elements of the transference. But despite my repeated interpretations, he remained adamant about his decision. They were married and then separated after six months.

Mr. A's father was a prominent abdominal surgeon who had operated on all three of his children at one time or another. In Mr. A's case, surgery had been followed by serious complications, entailing the insertion of a painful drainage tube due to an infection. The father seemed to have been devoted to his work, and had a rather distant relationship with his son; he was not demonstrative, although he cared and worried about the patient. His mother, also a medical doctor, was an extremely reserved person, unable to show affection, and came from a very troubled background. She had been raised in a village in another Latin American country, and met the patient's father while they were medical students there. Information about the patient's parents was extremely limited, yet it seemed rich in significant elements.

Mr. A had two older sisters. The first was married and had had a number of affairs without any attempt at discretion. The second had recently started a lesbian relationship. Needless to say, all this pointed toward complex sexual identifications within the family.

Certain important themes emerged in the course of the analysis. Mr. A was particularly attracted to male prostitutes who were transvestites; it was as though they were women endowed with penises. He became highly excited when they responded to his caresses with an erection. Occasionally, he performed fellatio on them.

With female prostitutes, another pattern emerged. Mr. A would go to massage parlors or brothels, or pick up women from the street, after which he would be masturbated by them or have them perform oral sex on him. He did not find this particularly gratifying; it only soothed him. What interested him was the possibility of taking such women away from their usual milieu and trying to redeem them. Occasionally, he would fall in love with one of them, and the relationship would end in disaster. His disregard for reality considerations was impressive in these situations. Paradoxically, these meetings rarely, if ever, ended in sexual intercourse.

Gradually, some fantasies began to emerge quite clearly. Mr. A could not consider a woman with a sexual urge to be "good," and believed that if she had such an urge, it was because she was "bad." This was expressed by the patient in religious terms. Educated in a Catholic school, he had been especially devoted to stories and images of the Virgin Mary, and could not reconcile sex and love in the same person (Freud 1912). Thus, he thought that the only possible solution was to "convert" a prostitute. This implied the presence of a Pygmalion-like fantasy, in which he would play the role of a redemptive father figure.

Another theme that emerged was a childhood recollection of seeing his elder sister in panties, with her legs spread, and discovering that where he had expected to see a penis, he could discern only a bushy void. This revelation had come as a shock to him. Castration anxiety themes came forward with clarity. He recalled that, after his surgery, he had dreamed of being in a room where the walls were covered with blood, and were "completely flat" (i.e., with nothing protruding).

Other significant information gradually emerged. Mr. A claimed to have been completely ignorant of the fact that his

mother had been married before, and that family rumor attributed her divorce to the fact that her former husband had been a pimp. All this material was reported in an extremely vague fashion, and he could not even recall how he had heard about it. He added that he had recently attended a party at his father's club, at which a known homosexual, who was drunk, told him that his father had been "one of them."

The analytic process proceeded without major disturbances. In the initial phase, Mr. A would tend to avoid a session after he had gone out to seek prostitutes or transvestites. He said he was ashamed and had difficulty in confiding this to me. I was thus perceived as a priest confessor or a representative of the establishment, someone unable to understand his particular preferences due to my "bourgeois" background. He frequently couched his complaints in Marxist terminology. This behavior subsided in the middle phase of his analysis.

The patient then decided to change his profession and to study archeology, while concurrently taking modern dance classes. I chose not to comment on these choices. I felt that both areas opened avenues that could allow him to undergo the frightening process of exploring his origins, as well as of examining his cross-identifications, in a setting that was not as menacing as that of the transference. To my mind, this did not represent acting out, but was rather a nonverbal expression of his conflicts and complementary to the work in analysis.

My reactions to the patient were of sympathy, interest, and liking. I felt him to be a very agreeable person. I enjoyed his intelligence and capacity for insight, but at times I was anxious about the possibility that he could develop AIDS, since he occasionally had unprotected sex. I caught myself occasionally feeling excited by some of his sexual adventures, as if fascinated by his lack of limits and the amazing facility with which he could seduce. His interest in transvestites and prostitutes subsided when he discovered a disinhibited and sexually active woman, who—if not at his intellectual level—could at least share his interests and understand him.

Mr. A's mixture of a rigid, Catholic upbringing and an idealization of Mary's virginity, the family myth of a prostitute mother, the surgical intervention by a castrating father, and the excitement of the forbidden had created a complicated amalgam that constituted his sexual identity, and these different elements could not be integrated. It was most difficult to subject this situation to any verbal intervention. Besides containing his turmoil of ideas and feelings, and allowing him to explore the contradictions and coincidences of these fragments of memories, my interpretations were aimed at finding (or perhaps constructing?) some sort of order amid this confusion.

What I would like to emphasize here is the particular manner in which I was able to listen to this patient. I had no difficulty in reaching out for clinical theory; on the contrary, I felt constantly flooded with it. Stoller (1968, 1975), Chasseguet-Smirgel (1984), Welldon (1993), and others came to mind. I was able, normally, to listen to Mr. A in a very relaxed fashion. The problem was in choosing between often contradictory theories. Themes such as castration anxiety, repressed homosexual desires, the patient's use of a particular infantile theory of sexuality—the phallic woman—to negate castration, his incapacity to integrate sexuality and tenderness or love, his fears about his bodily integrity, and the question of his origins were constantly present. With this patient, I felt close to the traditional Freudian concept of maintaining free-floating attention, and theory emerged in a similar free-floating fashion (see the discussion of Aulagnier in footnote 5, p. 148). My sensation was that I was constantly challenged in terms of priorities: what to interpret first, and how I could order all these contradictory views in a manner that would be of use to the patient.

THE CASE OF MR. B

In contrast to the previous case, I would like to present a briefer clinical vignette to illustrate a different way of listening. Mr. B was a 20-year-old university student who had been born with a

cleft palate. He was a very nice, shy person, with a young appearance that belied his age, undergoing three-times-a-week, psychoanalytically oriented psychotherapy. It could be argued that some of the difficulties I shall describe stemmed from the treatment setting and the frequency of sessions; I am, however, unconvinced that this is so. I believe that a more intensive frequency and use of the couch would not have substantially altered my way of listening. Furthermore, in terms of transference-countertransference developments, the sessions were rich in content, and taking into account reality considerations that did not permit his having more frequent sessions, he made considerable progress.

Despite having undergone surgery and various speech therapies, Mr. B had evident impediments, which led him to serious problems with his university classes. He was very bright and especially talented in poetry and in cinema, which provided adequate sublimations. Before I grew accustomed to his diction, I had difficulty in understanding him; this made me uncomfortable at first, since I often had to ask him to repeat a phrase.

The patient complained that he was unable to face situations in which he had to speak in public. This led to a phobic avoidance of his classes, and he would become very anxious about being asked to address the class, although he recognized that both professors and fellow students were extremely sympathetic to his difficulties. His appearance shamed him. He looked like a 15-year-old-boy, and people could hardly believe that he was twenty.

I felt very sympathetic toward Mr. B. His frail appearance, his shyness, and his obvious courage in facing his physical problem evoked in me both protective feelings and a sense of obligation to help him. I felt an urgency to understand and interpret him, being thus placed in the role of a benevolent father figure.

He came from a middle-class family. His father was an engineer, apparently an easygoing and caring person, while his mother, a housewife and somewhat stricter, came from a wealthier class. The family depended on the maternal business. The parents, whose relationship had been somewhat strained during

Mr. B's childhood (for reasons he was not able to specify), had recently joined a Catholic prayer group to which they dedicated a great deal of their time. They were extremely devoted to this activity, and continually insisted that the patient share their belief and commitment. He was not particularly interested and kept his distance from these practices.

The parents had apparently managed Mr. B's speech difficulties in an adequate fashion. They were not overprotective, and he was encouraged to lead as normal a life as possible. He had a one-year-older brother and a much younger sister. His relationship with them appeared to be very close, especially with his brother, who he felt cared for him. He remembered that as a child, he had often sought his protection, climbing into his bed at night.

Besides his difficulties at the university, which had reached their peak in the semester before he began treatment, Mr. B also complained about feeling depressed, and having indulged in alcoholic excesses in the previous year. He led a seemingly normal student life, had many friends, and experienced no difficulty dating. At the time he started therapy, he was going out with an attractive girl, and found the relationship sexually satisfactory. However, he felt that she did not share his intellectual interests; she seemed "hollow" to him, and he wondered if it would not be preferable to break up with her.

Mr. B was an avid soccer participant who played a couple of times a week, feeling very proud of his expertise. At the time of starting therapy, his references to the World Soccer Cup were very frequent. In a session toward the middle of treatment, he stated that this last tournament had been full of surprises, and that nothing was predictable about it. I pointed out that he was probably feeling that way about his analysis and about my interpretations. Suddenly, he asked me, point blank: "How do you explain the fact that I have always had the urge to make pointed objects?"

The question surprised me very much, as there had been no prior mention of this practice. Mr. B then explained that, ever

since he could remember, he had used his bed sheets, and later paper, to make pointed cones, which he would then put into his mouth. At the time, I was teaching a seminar on the Controversial Discussions (King and Steiner 1991), and my immediate and unexpected internal reaction was that this must be what Kleinians have in mind when they speak of unconscious fantasies. I wondered about the meaning of this compulsive symptom. Was it an attempt to build a prosthesis that would reconstruct his oral cavity? Was it the revival of a fantasy of the destructive "bad breast" that he unconsciously held responsible for his personal tragedy? (I knew he had not been breast-fed due to his cleft palate.) Was it both of these? Or was I merely postulating a reconstructive explanation of his symptom in the Freudian sense of *Nachträglichkeit?*

I realized that in listening to Mr. B, my attention was constantly fixed on his orality, without my having the liberty to fluctuate among alternative explanations of his symptomatology. It was as though this one factor captured me, in contrast to the freedom I felt in listening to most other patients; thus, theory did not come to my mind in the same free-floating fashion described in relation to Mr. A's analysis. Enmeshed in Mr. B's narration, I underwent a desperate internal search for a theory that could help me comprehend his unconscious understanding of his speech defect. Indeed, the remarkable thing about the sessions described is that, in fact, it was I who was unwilling to be surprised by new material. Instead of the material's evoking explanatory theories in a more spontaneous fashion, I experienced an active seeking of them. I would apply theory to the patient so as to understand him, and was impelled by an urgency to comprehend that blocked my spontaneity. My attention to other areas of his life, the possibility of more freedom in relation to my subjective reactions, and exploration of my own intrapsychic world at a more tranquil pace were thus impeded.

It is also of interest to note that my reaction to Mr. B's material was couched in a theoretical terminology alien to my favored inclinations. To me, this highlights the fact that no one

school of thought is able to explain all the phenomena we have to deal with—a point to which I shall return in my discussion of clinical theory. Thus, we are forced to both combine and to try to reconcile often contradictory concepts from different schools of thought, at times at the risk of indulging in eclecticism.

THE PROBLEMATIC NATURE OF CLINICAL PSYCHOANALYTIC THEORY

Many analysts agree on the existence of two levels of theory. One, the more abstract and distant, is the controversial one of a general theory of psychoanalysis, or what Freud called *metapsychology*. A considerable number of theoreticians would like to do away with what they believe to be an obsolete remnant of the nineteenth-century mechanistic philosophy of science (see Gill 1976; Habermas 1968; Klein 1976; and Ricoeur 1970, among others). On the other hand, many analysts consider metapsychology indispensable, even if it is conceived as a sort of shorthand on the basis of which analysts can formulate certain concepts without being sure of its scientific status. Freud (1914) considered it the most abstract level of theory, at the top of the pyramid, and that its conclusions could be interchanged without damaging the pyramid's base.

> One dislikes the thought of abandoning observation for barren theoretical controversy, but nevertheless one must not shirk an attempt at clarification . . . . Speculative theory of the relations in question would begin by seeking to obtain a sharply defined concept as its basis. But I am of the opinion that that is just a difference between a speculative theory and a science erected on empirical interpretation. The latter will not envy speculation its privilege of having a smooth, logically unassailable foundation, but will gladly content itself with nebulous, scarcely imaginable basic concepts, which it hopes to apprehend more clearly in the course of its development, or which it is even prepared to replace by others. [p. 77]

Thus, in Freud's view, the results of abstract speculation are inseparable from empirical material. Such speculation is necessary to guide us in the comprehension of clinical material. He also held that this necessity is not a problem specific to psychoanalysis, but is rather a general characteristic of the foundation of the sciences.

> We have often heard it maintained that sciences should be built up on clear and sharply defined basic concepts. In actual fact no science, not even the most exact, begins with such definitions. The true beginning of scientific activity consists rather in describing phenomena and then in proceeding to group, classify and correlate them. Even at the stage of description it is not possible to avoid applying certain abstract ideas to the material in hand, ideas derived from somewhere or other but certainly not from the new observations alone . . . . They must at first necessarily possess some degree of indefiniteness; there can be no question of any clear delimitation of their content. So long as they remain in this condition, we come to an understanding about their meaning by making repeated references to the material of observation from which they appear to have been derived, but upon which, in fact, they have been imposed. Thus, strictly speaking, they are in the nature of conventions—although everything depends on their not being arbitrarily chosen but determined by their having significant relations to the empirical material, relations that we seem to sense before we can clearly recognize and demonstrate them. [Freud 1915, p. 117]

It is often assumed that a more experience-near clinical theory is less debatable and could lead eventually to empirical verification. I would like to address the problems involved in this conception of clinical theory, and to comment on some of the theoretical alternatives that, although they have not solved the problem, could be useful in guiding clinical practice.

Theory in psychoanalytic clinical practice does not occupy the same status as in other branches of science. It could be argued, nonetheless, that similar problems occur in other sciences. (I will spare the reader the much abused comparison with Heisenberg's principle of uncertainty.[3]) The fact remains that the main problem with clinical theory in psychoanalysis is that it attempts to explain unconscious processes—that is to say, processes that, by their very characteristics, are alien to the logic of verbal ones. Furthermore, any interpretation affects the very clinical material it purports to elucidate. The consequences are twofold: (a) that any interpretation, however complete or comprehensive it may seem, is necessarily incomplete, and (b) the chain of associations that follows an interpretation is *ipso facto* affected by it.

Of course, these two conditions, which have been the constant target of scientific and academic attack, have nothing to do, necessarily, with shortcomings on the part of the analyst. They are consequences of the elusive nature of unconscious processes. In other words, they are due to the fact that by necessity, one has to interpret a primary process activity with verbal tools pertaining to a secondary one. Verbal interventions seek to enclose an aspect of unconscious functioning within a logical structure that is alien to its inherent contradictions and mobility.

True, it could well be argued that what the analyst interprets are fundamentally derivatives of the unconscious, and that precisely because of this, they are amenable to interpretations by verbal means. However, even if this is so, my contention is that any interpretation will necessarily be partial and will affect the content to which it is addressed. The purpose of interpreting derivatives is ultimately that of trying to understand the unconscious processes themselves. I insist that it is necessary to take this very important fact radically into account in our formulation of theory.

[3] Heisenberg introduced his principle of uncertainty in 1927 in a highly technical article, "Über den anschaulichen Inhalt der quanten theoretischen Kinematic und Mechanik." For a more accessible version of his ideas, consult his book, *Physics and Philosophy* (1958).

To look at a very common example, we might consider *ambivalence*. The analyst may certainly point out its presence to the patient, thus conveying an intuition that is useful to the patient. It is, however, impossible to literally transmit the simultaneous coexistence of love and hatred in a verbal formulation. We usually resort to symbolism and metaphor, either knowingly or unknowingly, to convey such abstractions in an effective fashion. Viderman (1970, pp. 194-195) offered an interesting case example: A patient dreamed that he laid six roses on the grave of his father. In French, the expressions for *cirrhosis* and *six roses* are completely identical phonetically. The patient was thus simultaneously rendering homage to his father and to the disease that killed him.

In waking life, it is impossible to process or to verbalize two such contrasting affects at the same time. As analysts, we can do so only by successive interpretations. As we well know, these are integrated into sequences, and constitute the only manner of transmitting that a particular patient both loves and hates his father, as in the example above. It is to be hoped that the patient will be able to intuit the intended meaning, since an attempt to explain that meaning verbally would clearly exceed the capabilities of a language subordinate to the logic of secondary process.

To give a short clinical example of my own, a patient dreamed that she had a vaginal hemorrhage, and that her hands were covered in blood. At that time in the analysis, she was complaining of feeling empty, and as though she were "being bled." In her associations to the dream, however, it appeared that the patient felt that her female organs were still present—notwithstanding the fact that she had undergone a hysterectomy. She feared, however, that they would become malignant. Dual ideas were being conveyed: both that of being barren, infertile, and emptied out, but also the fear that the return of fertility and menstruation (which the patient desired) would be dangerous. Thus, contradictory ideas were embedded in the dream. In analysis, we have to explain these contradictions in sequences, although they may appear simultaneously in fantasy.

These difficulties are compounded by the fact that we lack a unified theory of clinical interpretation. We use different dialects: Freudian, Kleinian, Kohutian, object relations, ego psychology, and Lacanian, among others—each, perhaps, with its own implicit metapsychology. Those of us who have had the good fortune to be trained in institutes that were not dogmatic in their teaching may have a degree of difficulty in claiming an affiliation with one school of thought. We thus find ourselves shifting constantly, when we hear a patient's material, from the perspective of one school of thought to that of another. This preferred way of functioning, in my opinion, is often perceived as an undesirable eclecticism. Of course, care should be exerted to avoid applying incompatible theories, but I submit that, to one degree or another, we have no choice but to listen from different theoretical perspectives. This solves the problem of being pluralistic without engaging in eclecticism.

Is it really possible to separate a clinical theory from metapsychology? Eagle (1984) presented a balanced view of the situation. Critics of metapsychology have pointed out its failings, its abstruse language, and the inapplicability of outdated concepts. However, the alternatives offered are far from satisfactory. In fact, what critics target is a specific metapsychology, but as Eagle pointed out, these critics are unable to separate abstract tenets from their conception of them. How can one speak of the unconscious without recourse to abstract theory, or primary and secondary process, or, indeed, narcissism? Both the hermeneutical and the Kohutian solutions are far from satisfactory. Schafer's (1976) approach is also open to criticism. Eagle (1984) noted that:

> [There are conflicts] . . . between clinical observations and the *current* metapsychology . . . . It is this search for the deeper level of explanation, rather than the specific content, that I take to be the significance of Freud's metapsychology . . . . The very idea of a purely clinical theory untainted by any trace of metapsychology is illusory. For example, the very notion of unconscious wishes and aims, so central to the clinical theory of psychoanalysis,

> inevitably entails metapsychological assumptions. [p. 149, italics in original]

There have also been important changes in our view of the analyst's relationship with the patient. We have evolved a long way from the paradigm of the analyst as a mirror, as described in Freud's technical papers, to the increasingly influential role of the analyst now being recognized as part of the intersubjective and intrapsychic nature of the analytic relationship. It is impossible to *relate* to a patient (here we can feel the inadequacy of the medical word *treat)* without being subjectively involved in an intensive manner. Indeed, the very existence of subjectivity is linked to the intersubjective relationship, as Husserl asserted (see Roudinesco 1993, pp. 129-130). Renik (1993a, 1993b, 1995, 1996, 1998) has written extensively on this subject, as has, from a different viewpoint, Green (1995, pp. 311-320, and 2002, pp. 37-76). Countertransference, broadly defined (Heimann 1950; Racker 1953), is no longer thought of as a manifestation of our failings, as it was previously viewed according to classical theory; it is now considered a useful tool for our work. What the analyst *feels* with the patient can constitute the basis of many of the interpretations offered. This recognition has led to a different conception of both transference and countertransference, i.e., as factors revealing themselves in the intersubjective and intrapsychic fields of the analysis, among which both analyst and patient are constantly shifting.

The complexities of the application of theory in clinical practice have been addressed in different ways. I shall discuss some that I have found useful.

ALTERNATIVE APPROACHES TO PSYCHOANALYTIC CLINICAL THEORY

One interesting approach stems from some of the French views of psychoanalysis. Without necessarily subscribing to Lacan's (1966) perspective, I nevertheless believe that his interest in

Hegel (1999) and dialectic logic has significant implications for psychoanalysis. At the time of Lacan's writing, Kojève (1969) and Koyré (1970) were also reevaluating Hegel's dialectic as expressed in his *Science of Logic* (1999) and *Phenomenology of Spirit* (1977). As is well known, French psychoanalysts of the time were closely in touch with the debates taking place in academia, as is attested to by the participation of Hyppolite (1974), one of the foremost specialists in Hegel, in Lacan's seminars (Lacan 1966, pp. 369-399, 879). There was a search for a theoretical model that could render the nature of unconscious functioning more closely than Freud's, and Hegel's dialectic appeared to be an attractive alternative.

We find in Green (1993) an extremely subtle and intelligent approximation to this problem in his conception of *le travail du négatif*. Hegelian logic appears to be a more accurate model of the mobility of unconscious processes than other static paradigms. In the work of Green, Hegel's influence is evident. Green has continually dealt with the contradictions involved in the possibilities of representation, and the hidden side of what is not represented, or that may be represented by its absence.[4] Another proposal that Green (1995) has put forward is that of *tertiary processes* linking primary and secondary processes (p. 151). What is thereby introduced is the complex theme of the relationship between primary and secondary processes and the possibility of mediating between them. This seminal idea deserves further exploration.

From another perspective, Winnicott's (1971, p. xii) discussion of the need to sustain a paradox, rather than trying to resolve it by reducing it to its components, seems to me a useful clinical model. This subject has been widely discussed. I have found particularly stimulating the special issue of *L'Arc* (1977), dedicated to Winnicott (1958), Clancier and Kalmanovitch (1984),

[4] This is not the forum in which to exhaustively discuss Green's contributions, but perhaps it is appropriate here to deplore the fact that so much of his important work has not as yet been translated into English.

Hernández and Giannakoulas (2001), Ribas (2000), Rousillon (1991) and—from a different perspective—Derrida (1998). When Winnicott submitted that an area of illusion is necessary for the discovery of reality—namely, that a baby needs to hallucinate the object before having it really presented—he actually formulated a most complex conception of the construction of reality (see Freud 1911). In deceptively simple language, Winnicott discussed several paradoxes. For example, in 1958, in his text entitled "On the Capacity to be Alone" (1965, pp. 29-38), he addressed the acquisition of the capacity to hallucinate the object and then realize its presence in relation to the actual presence of the mother. This paradox is considered in the light of the author's distinction between the subjective experience of internal reality, on the one hand, and external reality on the other.

In "Transitional Objects and Transitional Phenomena," written in 1951, Winnicott (1958, pp. 229-242) referred to his belief that the transitional object must be found to be created and created to be found. The environment must facilitate the finding of the object, and the baby then creates this first "not-me" possession. It is in this context that Winnicott reminded us that:

> I am drawing attention to the paradox involved in the use by the infant of what I have called the transitional object. My contribution is to ask for a paradox to be accepted and tolerated and respected, and not for it to be resolved. By flight to split-off intellectual functioning it is possible to resolve the paradox, but the price for this is the loss of the paradox itself. [1971, p. xii]

In exploring the antisocial personality in a paper written in 1956, Winnicott (1958, pp. 306-315) arrived at another paradoxical conclusion, this time in reference to defenses. Taking his lead from Freud's (1916, pp. 332-333) conception that guilt is not the result of crime, but rather that crime is the consequence of guilt, he concluded that antisocial tendencies reveal a hope of contact with the other. "In Fear of Breakdown" (1974), he addressed the fear of a breakdown that has already taken place.

Despite the controversy that Winnicott's conceptions may provoke, it can be extremely stimulating and productive to think of clinical material in terms of paradoxes. This approach is akin to that of the *travail du negativ* (Green 1993) in its tolerance of contradiction.

Another relevant point is the narrative form in which clinical psychoanalytic theory is described. Bersani (1986) has written provocatively about this theme:

> The normalizing intention within the Freudian text corresponds to an extratextual ambition crucial to both Freud's own career and to the entire history of psychoanalysis: the ambition of elaborating a clinically viable theory. The particular type of textual density which will interest us can therefore be defined as a tension between certain radical speculative moments and the wish to practice and even to institutionalize the speculative process itself. [p. 3]

Bion's (1994) injunction that the analyst should enter a session "without memory or desire" (pp. 380-385) exceeded the level of a mere methodological observation. It was, in fact, more than a radicalization of Freud's conception of free-floating attention; it was an idealization of it, as though the analyst could renounce his or her observing ego (Sterba 1934). Many of us question whether this is either possible or desirable. However, this statement underscores the fact that when one listens with "evenly hovering attention," clinical theory tends to appear in the form of "free-floating theory," to borrow Aulagnier's term.[5]

[5] Although I have been unable to find this specific quotation in Aulagnier's work, de Mijolla-Mellors (2002), who knew Aulagnier well and has authored a biography of her, commented that:

> This notion signifies the necessity to keep theory latent while one listens to the patient, and at the same time, the fact that this listening is impregnated by theory, which becomes thus "floating," that is to say, is mobilized, without becoming deforming . . . . I know of no text of the author [Aulagnier] in which she develops theoretically this notion that responds simultaneously to the criticisms of both atheoric empathy and the mechanical application of psychoanalytic knowledge.

The more the patient is fixed in a one-narrative form, the more difficult it is to grasp theory in this fashion. This phenomenon has been the subject of extensive examination in Spence's (1982, 1987) work, in which he put forward an extremely sophisticated hermeneutic approximation, and his descriptions of how we listen to patients merit serious consideration. Spence also made the point that narrative tends to both gloss over and to give undue coherence to the patient's associations, and he offered an interesting viewpoint of the way in which analysts really listen to patients.

There is one more approach to theory that I wish to briefly mention. It consists of the recourse to formalism to transmit the characteristics of mental processes, constituting an entirely different alternative to those discussed above. A clear example of this is Matte Blanco's (1975, 1988) *bilogic,* which postulated the coexistent operation of symmetric and asymmetric logic in the mind. This view was criticized by Skelton (1984, 1985), who contended that the principle of symmetry is incompatible with asymmetry within the same logical system. Matte Blanco (1984) responded to this criticism in a letter, in which he stated that, in his view, the two logical systems coexist without being part of the same system. Skelton (1990) later defended the use of logic in psychoanalysis, and expressed enthusiasm for Matte Blanco's use of set theory in formalizing the hierarchies of predicate thinking through his concept of generalization.[6] Personally, I find Matte Blanco's resort to logic of little practical relevance in clinical practice, although it is a valuable instrument to employ in thinking about mental processes, and in trying to grasp the admixture of the characteristics of primary and secondary processes.

Perhaps the most popular formal psychoanalytic theoretical model in contemporary psychoanalysis is Bion's (1962, 1963, 1965,

[6] Matte Blanco's work is extremely important to psychoanalysis, but too intricate to discuss adequately here. For an overview of his thinking, see the *International Review of Psycho-Analysis* 1990, 17(4).

1967) grid. Bion introduced his first preliminary reflections on this theme in *Learning from Experience* (1962), and proposed the grid itself and a rationale for it in *Elements of Psycho-Analysis* (1963):

> Because psychoanalytic theories are a compound of observed material and abstraction from it, they have been criticized as unscientific. They are at once too theoretical, that is to say, too much a representation of an observation, to be acceptable as an observation and too concrete to have the flexibility which allows an abstraction to be matched with a realization . . . . I propose to seek a mode of abstraction that ensures that the theoretical statement retains the minimum of particularization. [pp. 1-2]

Bion's use of a formal table that is at once sufficiently unsaturated to be capable of portraying psychoanalytic concepts, and sufficiently saturated to be meaningful, is original. His proposed system of annotation is a valuable aid to the analyst in reflecting back on a session. As previously mentioned, Bion (1994) was unambiguous about the necessity of the analyst's entering the analysis in a manner as free of memory and desire as possible.

A final Bionian attribute that I wish to mention here is his Kantian approach, evident from his first proposal (Bion 1962, p. 67; Bion 1963, pp. 6-9), in which he accepted the notion that it is impossible to know *things-in-themselves.* This belief took a more mystical turn in *Transformations* (1965), with his introduction of *O:* "I propose to extend the significance [of] O to cover the domain of reality and *becoming* . . . . Religious formulations come nearer to meeting the requirements of transformations in O than mathematical formulations" (p. 156, emphasis added; see also pp. 157-171). In summarizing, Bion stated:

> I shall consider O with the help of . . . Platonic Forms and their "reminders" (phenomena); "godhead," "god," and "his" incarnations; Ultimate Reality or Truth and the

> phenomena which are all that human beings can know of the thing-in-itself: all three possess a similar configuration. [p. 162]

Bion grappled with the issues of contradiction and the unity of opposites, resorting—in his later writings—to the idiom of mysticism and metaphysics. Such an option is fraught with risks that presumably he did not wish to court.

Psychoanalysis has shown an unfortunate propensity to fragment into quasi-religious sects. This is dangerous for our discipline, and, needless to say, was not what Bion intended. The questions psychoanalytic clinical theory raises are not satisfactorily resolved by the creation of systems that offer a relatively closed horizon of certitudes—notwithstanding their invoked containment of uncertainty.

CONCLUSION

The point of this paper has been to demonstrate some of the problems involved in the application of psychoanalytic clinical theory. The premise that it can be completely autonomous from metapsychological postulates appears to be untenable; metapsychological perspectives can evolve, but never disappear. What I have endeavored to show is that as clinicians, we are constantly faced with a flood of contradictory information, which we try to organize and arrange through the utilization of clinical theory. Of course, we have no alternative: it is indeed impossible to listen to a patient except from within a background of theory, even if it is implicit.

What I have tried to portray in this paper is the insufficiency of our clinical accounts. As soon as we try to mold our theories into narrative form, inevitably, something is left out. Clinical theory is thus of necessity incomplete; it cannot render justice to the contradictions present in unconscious processes, which are smoothed over in our accounts. We must remind ourselves of this fact, and remember that the nature of unconscious pro-

cesses is such that we must learn to live with contradictions and dilemmas. The essence of psychoanalysis is lost the moment that we renounce the uncertainty we are destined to tolerate. Our knowledge is always tentative and hesitant.

My case vignettes reveal nothing particularly complicated, and I am sure that many colleagues have experienced similar problems with their patients. And I am also sure that all of us, at times, feel the inadequacy of our communications about our patients; something is always missing in the narrative transmission of clinical material. My contention is that this stems from the impossibility of adequately transmitting primary processes in language inevitably bound by the logic of secondary ones.

I have discussed models that can help us think about our patients from different perspectives. Though not totally satisfactory, they have been useful to me in my clinical work. I have indicated that we are forced to live with different theoretical models, and must try to make them as compatible as we can. No one clinical model or theory can be sufficient to explain all of our cases, and recognition should be given to this fact. We are far from devising a unified psychoanalytic clinical theory, and it is debatable whether such unity is even possible.

Finally, we have to take up the formidable challenge of accepting that metapsychology cannot provide us with the unification of our theory. By their very natures, contradiction, free-floating energy (or any of its less mechanical substitutes), the lack of a reality principle, timelessness, and other characteristics of mental processes oblige us to renounce the possibility of a *Grund* or basis of certitudes. We are condemned to live in an irreducible subjectivity (Renik 1993a, 1993b, 1995, 1996, 1998), from within which our only fleeting glimpses of truth emerge from mutual recognitions during intersubjective and intrapsychic encounters with our patients.

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THE FUNCTION OF THEORY IN PSYCHOANALYSIS: A SELF PSYCHOLOGICAL PERSPECTIVE

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Although aware of a lack of consensus in the literature about the exact nature of the relationship between psychoanalytic theory and the clinical process, the authors contend that the analyst's theory(ies) are inextricably intertwined with the treatment process. Two clinical case examples are presented to illustrate this and to highlight the authors' discussion of the empathic mode of listening and its role in self psychology, as well as the selfobject transferences and the interpretive process in self psychology.

INTRODUCTION

There is a high degree of ambiguity in the psychoanalytic literature about the precise role and function of theory in the psychoanalytic treatment process. On the one side, there is a widespread, tacit (and often not so tacit) assumption that psychoanalytic theory (be it ego psychology, object relations theory, or self psychology) determines the nature of the analyst's interventions—in fact, that theory determines the analyst's entire conduct of the analysis: framing the setting and creating the clinical atmosphere, as well as choosing specific interpretive interventions. On the other side, there is a widespread, tacit (and often not so tacit) assumption that psychoanalytic theory is only loosely connected to the analyst's activities (including interpretations), which are more com-

pellingly guided by the affects the analyst may identify in the patient's verbalizations and behavior. It appears as though this latter group of analysts, focusing on the patient's leading affects, considers "atheoretical" listening and interventions not only possible, but desirable. As an outgrowth of this attitude, some analysts treat theory quite cavalierly, as if some parts of it, or all of it, could arbitrarily be discarded in favor of a more felicitous clinical approach—whatever that might turn out to be.

Alongside the ambiguity created by this polarization of views regarding the function of theory in clinical work, there is an added uncertainty related to the question of which theory is actually considered relevant or not so relevant to the treatment process: is it classic psychoanalytic metapsychology (which many have discarded); is it psychoanalytic clinical theory (of which there are many, and often contradictory, versions); or is it a not yet adequately systematized and agreed-upon theory of treatment and of "cure" that either determines, or is only loosely connected to, what we do as analysts?

These questions have become more important—one might even say more urgent—as the need for a comparative psychoanalysis has emerged in the wake of advances in the ego psychologies, the object relations theories, and the self psychologies during the past two decades.[1] Thus, a reexamination of the nature of the relation between theory and clinical process, and making this relation as explicit as possible, has become necessary, in order to determine what makes all these current trends in theory building and practice *psychoanalytic*—even while each is fundamentally different in its developmental theory, metapsychology, and clinical theory, as well as in its theory of treatment and "cure" or change. Such a reexamination might lead us to achieve needed refinements in theory, and thus also to refine the interpretive process in the clinical situation.

[1] We are using the plural here for all three of the main current trends in psychoanalysis, because there is no longer a clear unity or uniformity even within each of the major theoretical systems referred to, which creates additional difficulties for any "intersystemic" discourse.

THE GENERAL FUNCTION OF PSYCHOANALYTIC THEORY

The thesis of this paper is that the analyst's preferred (public) psychoanalytic theory (co-mingled with his or her private theory) is inextricably intertwined with every element of the treatment process, including its outcome.

Thus, we begin with the simple but compelling statement that there is no way in which any of us can avoid the use of theory in the analytic treatment process. That is, we cannot listen to our patients and interpret the meaning of their communications without having *some* theory. The naive assumption that empathic listening can be theory free, that such empathic listening can lead directly to the raw data presented by the patient, is a myth. As soon as the analyst responds to what the patient says, he or she begins to shape and thereby to alter the patient's associations. The analyst's mode of listening and his or her interventions transform that raw data into psychoanalytic data, and these are then the data usually presented and discussed.

Perhaps the best way to dispel such a myth is to examine how it might have arisen. Each clinical presentation we listen to quickly reveals the existence of two artificially separable, but in reality thoroughly intertwined, layers of experience in the analytic situation. The first layer of experience consists of the clinical atmosphere created by the analytic dyad: for example, how patient and analyst greet each other; how the issues regarding the fee are negotiated; how silences are tolerated by each; and so on. The experiences in the first layer are affected by the experiences in the second layer. The impact of the analyst's particular public theory can be more readily discerned in the second layer, based on what the analyst selects to comment on—what areas he or she chooses to investigate and to interpret.

The naive viewpoint mentioned above considers the first layer to be theory free, the assumption being that no specific theory is required to create the proper analytic atmosphere—we do this naturally in everyday conversations as well, that is, we create the

proper climate for meaningful interchange. The same applies to analytic listening and to the way we ordinarily communicate with each other in everyday life. This view seems to disregard the fact that the private, unarticulated, informal, common-sense notions we harbor operate as theories in our everyday lives, and that they therefore inevitably form a part of every aspect of our professional endeavors. In other words, every deliberate human activity is saturated with theory—we always act on the basis of our unarticulated private theories, including our unconscious fantasies. Nothing we do or say can thus be theory free. But we are not accustomed to regarding our informal conceptions, those underlying all our activities, as theories, and that seems to be why the myth of theory-free listening and responding has arisen. Furthermore, this myth has been buttressed by the fact that, once we have been analyzed, we consider ourselves to be reasonably reliable instruments for analyzing others. And since under favorable conditions, we are not consciously aware of the theory we are using at any particular moment in the treatment process—it is now "in our blood and bones"—our self-concept, too, adds to the illusion of theory-free listening.

A MODE OF OBSERVATION AND LISTENING: THE EMPATHIC VANTAGE POINT

The idea that the analyst should listen to the patient's free associations with evenly hovering attention does not adequately describe the particular mode of observation and cognition most appropriate to making contact with the patient's inner world. Evenly hovering attention per se does not direct us toward either extrospection or introspection (or "vicarious introspection"—that is, empathy). An attitude of "hovering" is characterized merely by a maintenance of openness toward the patient's communications through the avoidance of premature closure as to their meanings, and by the assignment of equal weight to all elements in the stream of free associations. However, since in this mode of

listening, analysts are asked to focus on the sequence and juxtaposition of associations, especially those with affect-laden and symbolic imagery (related to transference and resistance), such associations inform the analyst of the patient's subjective experiences only *indirectly*—once removed, as it were. This overall observational and listening stance is fundamentally one of extrospection, even if introspection (empathy) is incorporated in order to make contact with the patient's feeling states. With extrospection, the observer/listener will have stopped short of reaching the central goal of analytic explorations, namely, to get hold of the patient's subjective experience more directly—and the analyst will then tend to make up for this omission by turning to a predominantly theory-based inference to understand the patient's subjective experience.

We maintain that evenly hovering attention could also be employed to lead the analyst in the opposite direction, namely, to a more predominantly introspective (empathic) mode of observation and listening. Here, extrospection—while inevitably also operative (we always register what is immediately observable)—is deliberately more peripheral and subordinated to the process of a prolonged empathic immersion in the inner life of the patient, and especially in the patient's transference and resistance. This empathy-based listening/observing gives us the most direct access to the patient's subjective experiences and to his or her complex, multilayered motives for constructing them. The questions the analyst may internally formulate are these: "How does the patient experience him/herself? How does he/she experience me, and how does he/she experience him/herself experiencing me?"

These questions necessitate the use of vicarious introspection (or *trial identification* or *transient merger,* in other theoretical contexts) to permit more direct contact with the patient's inner life. Here, too, the sequence and juxtaposition of associations, as well as of particularly affect-laden and symbolic imagery, are, of course, noted; but attention does not remain riveted on them as *isolated or discrete phenomena.* Instead, such factors serve as

points of entry into the patient's inner life, in order for the analyst to grasp the patient's total experience of the moment. In the course of analysis, with ever deepening levels of understanding, it is this same listening perspective that illuminates those aspects of the patient's inner life that are unavailable to his or her awareness due to disavowal or repression. In the introspective-empathic observational mode, the analyst is continuously focused on the *experiencing self*.

In principle, then, two approaches—the extrospective and the introspective (empathic)—always naturally co-mingle, but one or the other is predominantly employed in a given analytic process. Our main point here is that the nature of our interventions and the data we obtain as a result of them will be significantly determined by the choice we make between these two approaches.

The Centrality of Empathy in Self Psychology

There are two reasons why empathy, or the empathic vantage point of observation, has attained a central position in the psychoanalytic process as guided by self psychology (Kohut 1959; Ornstein 1979):

(1) For Kohut, empathy as a mode of observation defined the field of psychoanalysis, in that whatever could be grasped or potentially grasped via empathy defined the boundaries of psychoanalysis as a pure psychology.

(2) Empathy is the only method that gives us direct access to the patient's subjective inner experience—an important starting point for the exploration of the patient's inner life, not to be bypassed in favor of attempts to get hold of the patient's unconscious motives without first grasping his or her immediate experience. There was a time when empathy was viewed as a way of making contact with the patient's feeling states, identifying the leading affects—but

> this fell short of the idea of *feeling oneself and thinking oneself into the inner life of another,* which is the current definition of empathy.[2]

Without recognition of the centrality of empathy-based data, both in theory formation and in clinical usage, self psychology cannot be fully understood and appreciated. This observational mode leads us to the recognition of how the patient experiences us, how and for what purpose he or she needs and uses us—which then leads to the recognition of various selfobject transferences, to which we shall now turn.

SELFOBJECT TRANSFERENCES

The recognition of *selfobject transferences* (Kohut 1971, 1977) provided the empirical data from which the bridging concept of *selfobject*—an awkward neologism—arose. We call the selfobject a foundational construct of self psychology because all else of significance in the theory can be derived from it. The selfobject (or more accurately, the *selfobject experience)* brings the outer world into the inner world in that it focuses our attention on how the patient experiences that external world—and thus, external reality becomes a part of inner experience. For example, in manifestations of selfobject transferences, analysts may discern how they are experienced in the analytic process, and what the patient is searching for and needs from the analyst. It is that particular need, based on the specific deficit that becomes activated in the analytic situation, that characterizes the various selfobject transferences.[3]

[2] We are aware of the manifold criticisms of empathy in the contemporary literature, but this essay is not the appropriate context to discuss these or to respond to critics.

[3] Because these transferences are based on developmental deficits, rather than on drive-related conflicts, Kohut (1971) first described them as *transference-like,* noting the patient's experience of the analyst as the continuation of early reality.

Clinical Example: Mr. M

To illustrate this point, we have selected a dream from the second year of an analysis conducted by one of us (A. O.). We are not claiming here that the diagnosis of a mirror transference can be made on the basis of one dream alone. However, dreams do crystallize and vividly represent an infantile wish that may be otherwise hidden or defensively distorted; a dream can therefore be used to demonstrate the presence of a particular transference that would otherwise require a lengthy clinical presentation.

Mr. M, a 32-year-old, divorced man, entered analysis because of a severe writing block: he had difficulty completing written reports, which seriously interfered with his advancement in his chosen field. The dream occurred during a period in the analysis in which the patient was particularly pleased with the progress he was making; he had begun to speak up in groups, was less concerned about sounding stupid, and had been able to hand in written reports to his superiors. He was pleased with the dream, too, because it was in multicolor, which he interpreted as representing an increase in his ability to experience strong affects.

> The dream depicted a busy street in a famous city, where I was to play a musical instrument. As I was about to play, I looked up and saw you [the analyst] in the window of one of the buildings. I knew it was you, though I could not make out your features from that distance. This made me anxious, and when I tried to play, the music did not sound right. When I woke up, I felt uncomfortable.

Mr. M first associated to the vagueness of the analyst's face. He said that he wanted me (A. O.) there so that I would listen to him play, but that he was probably worried about what my face would look like, and this was why he could not see my face clearly. I agreed, and said that he must have been concerned about whether my face would display pleasure in seeing him and in hearing him play, or whether my face would be dull and indifferent.

His next association was to a memory—"or was that a dream also?" he wondered.

> I was in a large auditorium and was to receive a Boy Scout medal. I thought I saw my mother in the back of the auditorium, but again, I could not make out her face. I have thought about this memory often, and wondered whether or not my mother was really there; she rarely came to events like this, as she suffered from a chronic illness that kept her in bed much of the time.

The patient, an introspective and sensitive man, interpreted the memory/dream in all its details: the longing for his mother's approving smile; his wish that he could have had the power to make her physically and emotionally well; and his fear that again this time, he would not have the capacity to bring a smile to either his mother's or his analyst's face.

In the first dream, the reactivated childhood wish to be seen, validated, and admired was expressed in action taking place on the street, where Mr. M was to perform and be watched. In the transference, the wish was stimulated by progress in the analysis—that is, the wish for the analyst to take note of that progress and to be pleased by it. However, the transference need had deep genetic roots; it reached to a time in childhood when the acquisition of new skills went unnoticed by both parents, primarily because of their preoccupation with the mother's illness. It was then that his schoolwork had begun to decline, and he became increasingly more withdrawn. The mirror transference in this case arose in relation to a deficit relatively late in the patient's psychological development. This may explain the essentially neurotic organization of his personality. The working through of the mirror transference constituted a direct link to the progressive amelioration of Mr. M's writing block and the difficulty he had in displaying his written work.

It could be argued that the patient's anxiety might have expressed sexual concerns—that the instrument he was to play represented his penis, and that his inability to play represented

castration anxiety. Such a formulation of the dream, however, does not invalidate our understanding that this was a mirror transference. A little boy who displays his penis to his mother anxiously awaits her response: will she delight in him, or will she meet his proud display with indifference—or worse, with disapproval? During the oedipal phase, too, we are concerned with the nature of the selfobject responses: the parent who is in tune with the need at this developmental phase to be seen and admired will neither respond with a (potentially traumatizing) rebuff, nor with an attempt at gratification that would turn the child's healthy sensuality into sexual arousal.

In relation to the establishment and working through of a mirror transference, we need to emphasize that the analyst does not "mirror" by simply reflecting the patient's affect or state of mind, such as "I know how you feel" or "I understand your agony"—empty, general statements, which do not impart meaningful, usable understanding. This type of transference must be interpreted and its genetic roots reconstructed in keeping with well-established psychoanalytic principles.

The Idealizing Transference

We shall now turn to a discussion of the idealizing transference in its most frequent manifestations. Idealization of the analyst may be a part of every analysis. The expectable idealization of one's analyst does not mean that the analysand has developed a cohesive idealizing transference in which the analysis has reactivated structural deficits related to the "values-and-ideals" pole of the bipolar self. An idealizing transference is one that becomes established either (a) in relation to archaic idealizing needs, in which the analyst is experienced as a source of power and strength, who in his or her infinite wisdom, will always be there to ensure the analysand's sense of safety and/or perfection; or (b) as one originating in a later developmental phase, in which the analysand sees him- or herself as merged with the analyst's wisdom and omniscience, and thus experiences the self as unique

and special by virtue of association with this unique and special analyst.

Mainly because they are silent, idealizing needs in the early phases of an analysis may be dismissed as peripheral to the evolving transference. However, a silent idealizing transference must be recognized as the background presence against which the verbal content of the analysis is expressed. Under these circumstances, the idealizing transference can be seen to provide a sense of safety that permits exploration of painful infantile affects and the conflicts related to them. That it is the background presence of the analyst's empathic understanding (representing the analyst's "perfection") that constitutes the essential aspect of the transference can only be appreciated when the patient experiences an unexpected and massive disillusionment in the analyst's idealized perfection. It is the disruption of the silent idealizing merger transference that brings not only its dynamic but also its genetic significance to the fore. Such a disruption may come as a surprise to both parties, and may be related to something that, to an external observer, would appear to be an innocuous event—which, however, on closer examination, turns out to have deep, genetically determined significance.

The disruption of an idealizing transference may take many forms. When the disruption provokes a narcissistic rage reaction, whether expressed directly or defended against by haughty withdrawal, it may usher in the revival of a childhood experience in which traumatic disappointments in the parents' perfection were experienced as deliberate efforts to hurt the child. Blaming the analyst for the disruption often represents an attempt to overcome a sense of vulnerability, which the disruption has exposed. In carefully reconstructing the disruption, it is important to remember that the rage reaction can only be understood when placed into the context of the selfobject transference experience. It is then that an event that otherwise appears insignificant can be understood—first in the here and now (in relation to the analyst), and later in its full genetic significance.

It was on the basis of the working through of the selfobject transferences that Kohut formulated his developmental theory,

the theory of psychopathology, and the theory of treatment; and it was also the selfobject concept—namely, our lifelong need for selfobject responsiveness—that helped him to set up criteria for termination.

The Concept of the Selfobject

The recognition of selfobject transferences helps us to appreciate the far-reaching significance of the concept of the selfobject as a developmental and clinical factor. In its relatively short life span, the concept has been in constant evolution, and has increasingly been applied to the understanding of cultural and religious phenomena.

Because of its significance in self psychology, we shall briefly delineate the meaning of the selfobject from other, better-known psychoanalytic concepts such as *pre-oedipal object, part object,* and *need-satisfying object.* It is often assumed that the selfobject concept is synonymous with, or at least closely related to, all these concepts—so closely, some believe, that the selfobject is merely a new term for well-known and well-established developmental processes and events. Such misconceptions easily occur if the selfobject is not examined with clear and unambiguous reference to the introspective/empathic mode of observation, within the clinical and theoretical framework in which it developed.

To indicate the distinctiveness of the selfobject concept, we shall take a closer look at the *need-satisfying object,* an object that is party to an anaclitic relationship. According to Anna Freud (1952), the need-fulfilling anaclitic relationship is based on the urgency of the child's needs and drive derivatives, which fluctuate, since object cathexis is put forth under the impact of imperative desires and withdrawn again when satisfaction is reached. In the case of the need-satisfying object, the external observer takes note of the changing *relationship* between caretaker and infant, while in the case of the selfobject, the reference is to the infant's *experience* in relation to the caretaker, its changed mental

state. The infant's experience will depend on the manner in which the interaction takes place: the way the infant is held, gazed at, and spoken to—these are the caretaker's selfobject functions, and it is they, rather than the fluctuating drive needs, that affect the infant's self-state.

The concept of the need-satisfying object is in keeping with Freud's theory of libido distribution and the process of separation between self and object. It is derived from Freud's (1914) formulation of primary and secondary narcissism. After Freud abandoned the idea of two different sources of psychic energy —ego libido and sexual libido—he postulated a primary form of libido, which contained all libido. It was from this common pool, expressed in the well-known metaphor of the amoeba, that under the impact of fluctuating drive needs, libido would be sent out to cathect the object. This mode of investment of the object with libido was described by Anna Freud as the infant's developing anaclitic relationship with the mother. Subsequent developments in Freud's theory, as well as the contributions of others who addressed the issue of narcissism and its relation to objects, retained Freud's single-axis theory of narcissism. However, results of infant research over the last few decades has supported the self psychological view that, rather than having to *separate* from an undifferentiated autistic state, the human infant is born with the capacity (and the imperative developmental need) to *connect* with the primary caretaker. The caretaker's selfobject functions play a pivotal role in the establishment of this connection.

Both the observations made about infants and those made in the clinical situation make it clear that the selfobject concept cannot be separated from the concept of the self. In the clinical situation, for example, the analyst is used by the patient for a particular, internally unavailable function. Selfobjects are objects that we experience as parts of our self:

> The expected control over such selfobject others is, then, closer to the concept of the control which a grown-up ex-

> pects to have over his own body and mind than to the concept of the control which he expects to have over others. [Kohut 1971, pp. 26-27]

But how do we know how one person experiences another? How does a person's behavior, tone of voice, and choice of words affect the state of mind of another? Since our attention is consistently focused on the *meaning* that our manner, actions, and verbal communications have on the patient (rather than on their actuality or reality), the analyst's task is to grasp these meanings.

It is here that empathy as a mode of observation becomes linked to the recognition of selfobject transferences. In other words, we are emphasizing the intrinsic, inseparable relationship between a method of observation and the resultant findings. It was Kohut's most striking early observation that when transferences were permitted to develop in which the analyst was experienced as if he or she were part of the patient's self, the working through of these transferences led to the transformation of archaic narcissism into more mature forms, rather than directly into object love. He expressed this empirical observation in postulating the existence of separate lines of development (though not independent ones) for narcissism and object love.

THE INTERPRETIVE PROCESS IN SELF PSYCHOLOGY

When Kohut introduced a decisive shift of emphasis in the definition of psychoanalysis as the psychology of complex mental states, and explicitly recognized interpretation as a two-step process of *understanding* and *explaining,* he significantly narrowed the then-existing gap between theory and practice. By emphasizing the importance of understanding—which did not have a separate theoretical and clinical significance prior to that time—he changed the prevailing, one-sided definition of psychoanalysis as merely an "explaining psychology" (Eissler 1968; Hartmann 1927) to one of an "*understanding and* explaining psychology" (Kohut 1973, 1977; Ornstein and Ornstein 1985).

The empathic mode of observation and listening leads us to an understanding of the patient's communication that requires at first only our common-sense, essentially immanent personal knowledge, which is based on our own life experiences, including our analytic self-knowledge. Explanations (interpretations in the narrow sense) arise out of deepened understanding, informed by the specific psychoanalytic theories that serve as our tools (Hartmann, Kris, and Loewenstein 1953)—or, more specifically, as our tools of observation (Kohut 1973). If theories were more consistently used as tools of observation and were not built into the method itself by definition, the second layer of our approach could remain potentially open, or could at least be more easily reopened, for the addition of new observations from time to time.

With this emphasis on understanding, Kohut transformed a relatively closed system into a more open one. In other words, to the extent that we have incorporated certain specific explanatory theories (such as, for instance, the Oedipus complex) into the very definition of the analytic process, we have locked theory and practice into an almost unalterable vicious circle; we have created a closed system. It is at the level of understanding that the circle from observation to theory, and then the feedback from theory to observation, may be most effectively opened. Periodic oscillations between openings and closures—in the relation between theory and practice, on a more limited scale, and a few notable openings and closures that amount to paradigm changes in our field, on a larger scale—are a part of the history of the development of psychoanalysis.

Understanding has become a significant part of the interpretive process also on the basis of Kohut's clinical observation that some patients need a prolonged period of understanding before explanation can be useful to them. Tentative understanding can be deepened within the analytic dialogue. In this dialogue, the analyst's verbal and nonverbal interventions affect the patient's responses—thus, self psychology has also made psychoanalysis more of a dialogic treatment process than it was before.

The concept of the analytic process, an identifiable "red thread" within the analytic experience as a whole (Ornstein 2002), is illustrated by the fact that the interpretive activity of the analyst must always be guided, throughout the entire analysis, in relation to the specific selfobject transference mobilized. This was the case in the analysis of Mr. M (discussed above), whose two dreams portrayed his yearnings to be seen, smiled at, and admired—which remained at the center of the patient's analysis throughout, demonstrating an identifiable analytic process and the close connection between theory and practice.

The mirror transference (and any of the other selfobject configurations) serves as a frame within which the specific needs, wishes, demands, and fantasies of the patient have to be discovered in the here and now, as well as genetically. Recognizing the specific configuration of the selfobject transference does not yet connect the analyst to the patient's specific expectations; rather, this recognition tells the analyst in a global way where the patient is, and offers a tentative identification of uncharted terrain, in which the various unique landmarks have yet to be painstakingly, jointly, discovered.

Clinical Example: Mrs. A[4]

Mrs. A was a widowed, professional woman in her late thirties, who came into analysis with one of us (P. H. O.) some years ago because of chronic depression, apathy, and a profound inability to experience any sustained or sustaining joy or pleasure in either her personal or professional life. She made excellent progress over a number of years, especially in the core areas of her initial difficulties: she had wanted to feel more comfortable with her body as a woman, and now she did; she had wanted to shed her "masculine, tomboyish" self-image and to feel comfortable in feminine clothes; and, later on, she wished to be less

[4] This example has also been used in another context, for a different purpose and with a different emphasis (Ornstein 1993, p. 149).

frightened of intense bodily sensations and of sexual feelings on the couch. These latter goals she had also attained to a degree.

In the particular session on which I wish to focus first, Mrs. A complained (again) about what she did not like about herself, especially her body. But there was a new item: "I don't like my voice," she said. I asked her why not—what didn't she like about it? She proceeded to respond to the question, but I noticed that she did so somewhat halfheartedly, as if she had suddenly lost interest in talking about it. She spoke without the intensity with which she had uttered her complaints prior to my having interrupted her with my question. At some point a bit later—I can no longer recall the moment, or my intervention, precisely—I said something to the effect that here was suddenly something else about herself that she disliked, and how hard it must be for her to live in her body while feeling that nothing about her was properly feminine. The session ended on that note.

Mrs. A started the next session by returning to this episode with muted fury. She recalled that first my question, and later my statement, made her feel "shut out"; they gave her "a punch in the belly." She heard in my voice some kind of disbelief or consternation regarding the fact that she did not like her voice. She felt challenged by my question, as though it implied that there was nothing in her voice for her to dislike.

At this point, I realized that I had indeed been startled by her new complaint, and suddenly recalled the tone of my voice, which had, in fact, expressed my unspoken feeling of "My God, what is she complaining about, she has a very pleasant voice!" And it dawned on me that it may well have been this same feeling that was responsible for my asking the question that made her feel challenged. As I was musing about all of this, the patient continued to describe how anxious she had been during the previous session while talking about her dislike of her voice. She wanted me to know how she felt, she said, but mainly, she wanted me to approve of her courage in having brought up the subject for discussion.

"So the challenge you heard in my voice," I said, "was certainly not the approval you hoped for. Then you seemed to lose interest in telling me more."

"Yes—it stopped me cold! And when you said I should learn to live with it—that's how I heard it, anyway—I felt you had dismissed me. And then I felt the same emptiness I always felt with my mother." Mrs. A went on to recall a childhood episode in the kitchen, one of many similar episodes, in which her mother was preoccupied with some cooking activity. The patient very much wanted to be with her mother; wanted her attention, and wanted to join in her activities. Finally, exasperated, she asked her mother for something to eat. Mother turned away (as the patient remembered it) and continued to wash dishes without having responded to her request.

"A scary feeling, that emptiness," Mrs. A now commented. "I feel helpless when it comes on. My anxiety attacks begin with that feeling." She compared her feelings in the previous session with the experience of having her mother literally turn away from her when she was hungry and had asked for something to eat.

"So yesterday, you were hungry for my approval," I observed, "but I turned away from you."

"I was hungry for *contact* and approval," Mrs. A replied, "and you turned away. It made me feel shut out."

This brief clinical vignette highlights several clinical-theoretical principles of a self psychological perspective. It demonstrates the importance of the analysis of disruption in a mirror transference, which in this case was related to my departing from the empathic listening position. I could not conceal my irritation with Mrs. A (nor my preoccupation with my own agenda) over the fact that she had brought in still another feature of herself that she disliked—although, as is true of all countertransference reactions, I was not conscious of this at the time. The patient experienced my consciously exploratory intent regarding her dislike of her voice as a challenge, and she correctly perceived this as an expression of my unrecognized assertion that she had

no grounds for disliking her voice. While I noted the patient's untoward reaction in the form of her loss of interest in pursuing the topic she herself had introduced, I did not discover the reasons for her reaction until the next session. I had assumed that her lack of interest, bordering on a mild depression, was simply the result of the fact that her dislike of her voice—another of her many subjectively unfeminine, and therefore hated, features—had surfaced with some intensity. Thinking that the sudden change in her mood was related to the revelation of a new symptom, I commented that it must be hard to live with such feelings. Little did I realize at the end of the session that my attempt at empathic contact with Mrs. A's depressive reaction was off the mark.

The patient's response the next day helped me to discover that what she heard in the tone of my voice (consternation and disbelief) was in fact what I felt. I also realized that this same feeling of mine might well have motivated my challenging question. While I sensed that the patient wanted me to know how she felt—and I tried to respond to this by acknowledging the pain she must be living with—she also helped me to recognize the unconscious aspects of my communication, contained more in the tone of my voice than in what I considered to be "a simple question." I could now understand why Mrs. A had experienced my query as a punch in the belly and why it had made her feel shut out. I had missed completely the stronger and more profound wish that I recognize and applaud her courage to talk about her dislike of her voice.

This kind of interchange is an everyday experience in the life of an analyst. The differences in our individual responses will depend on how we understand the nature of the transference and whether or not we look at this from an empathic vantage point. If Mrs. A's transference were understood as a distortion or displacement (i.e., that she experienced the analyst as though he were her mother), then the interpretation offered would have to be formulated according to that understanding; specifically, it would have to call attention to the patient's having distorted

and displaced experiences from her past, making her here-and-now reaction an "inappropriate" one. This is essentially an extrospective view of the transference, and it would not lead the analyst to consider the manner in which he or she might have triggered the patient's reaction of feeling challenged, invalidated, and ultimately empty.

A self psychological view of transference takes the analyst in a different direction. Rather than viewing the transference as a distortion and/or displacement, the analyst must make an effort to enter the patient's inner world in order to recognize how he or she is being experienced. This emphasis on the patient's experiences in relation to the analyst, and the patient's use of the analyst as one who can potentially facilitate the resumption of a thwarted need to grow, prompted Kohut to describe such transferences as *selfobject transferences*. In the case of Mrs. A, viewing the transference in this manner helped me to avoid becoming entangled in the question of whose reality was more accurate or valid. I did not focus on the *conscious intentions* behind my questions; neither did I bypass the patient's immediate experience to home in on what childhood traumata might have predisposed her to react to this intervention in the way she did. In the next session, I implicitly accepted her claim of having felt traumatized by my question, and recognized the aspects of my intervention that had provoked this reaction in her. If I had dismissed Mrs. A in the previous session, I now accepted her by freely, nondefensively, and nonaccusingly reconstructing with her the experience of the previous session. Thus, the transient rupture in the analytic relationship was healed—a disruption in the mirror transference was *interpretively* repaired. I did not have to admire Mrs. A belatedly for her courage; I had only to acknowledge that not having recognized her wish for this during the earlier session explained her subsequent reaction. As so frequently happens at such moments, the patient herself supplied the genetically significant childhood memory, which had left behind the vulnerability that my questions now traumatically reactivated.

The effort to reconstruct the disruption with a primary focus upon Mrs. A's experiences from her own vantage point deepened the analytic process. Deepening was reflected here both in the early memory the patient recalled, and in the joint recognition of how an empathic failure regarding her specific vulnerabilities repeated a childhood trauma.

In our view, such reconstructions move the analytic process forward for several reasons: first, patients feel validated in their experiences, a structure-building experience for someone whose needs and wishes were dismissed in the past; and second, patients become more keenly aware of their own vulnerabilities and their genetic antecedents: the immediacy of a validating experience is thereby coupled with insight. In addition, the reconstruction of the disruption permits a dialogue on the level of the most immediately felt, deepest longings of the patient as these relate to—and are in fact actually mobilized within—the analytic experience itself. My empathic immersion in Mrs. A's transference experience allowed for a focus on the dynamics and genetics of her analytic experience itself, in contrast to the dynamics and genetics of her psychopathology. When transference longings are interpretively thwarted (by not being recognized or considered legitimate in the light of infantile or childhood experiences, or as a result of miscarried neutrality or abstinence), they tend to become stubborn resistances. Just as infantile and childhood traumata transform needs and longings into noisy and persistent demands in the face of excessive frustrations, so do unempathic or non-empathic interventions during psychoanalysis or psychotherapy.

Another brief vignette from the analysis with Mrs. A, recounted below, highlights an often noxious focus on the dynamics of the psychopathology, instead of the dynamics of the analytic experience itself, namely, the transference.

At a later point in the analysis, Mrs. A went to a convention for several days with her colleagues, both male and female, to a city she knew well, having lived there previously. She was at the center of the group's attention, since she knew what sites to see,

what restaurants to go to, and so on. A certain closeness and intimacy with one of the men, Mr. T—in the sense of sharing these experiences and being able to talk about them meaningfully, rather than merely superficially—lent her trip a particular poignancy. Her usual dissatisfactions with herself, which tended to inhibit her socially because she felt that others might share her dislike of herself, were absent. She was outgoing and enjoyed it all. Toward the end of the trip, she began to regret the approaching termination of her intimacy with Mr. T, and described how she withdrew and turned inward again. She hated the thought of saying goodbye at the airport. She lost her ease of relating. She felt impatient to leave her companions—she wanted to get it over with quickly—especially the man with whom her Platonic friendship had blossomed and achieved more depth than before. She knew that it was all going to end, and she wanted it over with quickly.

"Do you know what I'm talking about?" she asked me abruptly. I responded by commenting, "You wanted to leave him before he left you." "Sure," she said—and fell silent.

I thought I had captured the main theme of her associations and reflected it in my all-too-brief statement to her. I was not quite aware of having made it somewhat laconically—but as soon as she said "Sure," with an edge to her voice, I realized the casualness with which I had offered her a formulaic response.

Mrs. A soon broke her silence with anger, saying, "I wasn't going to get into a fight with you, but you picked that answer out of a book—you didn't listen to me! Now Dr. O, that's not your usual response when you listen—you don't usually sound so wooden when you listen to me." There was a short pause, followed by: "What have I done to deserve this? This was very important to me—you know—and very difficult to talk about!"

I was not aware of the woodenness in my voice until the patient mentioned it. Her comment helped me to reconstruct quickly what had happened to me. First, in listening to her description of her successful trip, I was seduced by the content, recognizing an old pattern of hers and expressing it concisely

in that well-known and well-worn, dynamic formula: "You wanted to leave him before he left you." But why? Only after I replayed the sequence quickly in my mind did I realize that the latent content of her message had eluded me. It had to do with her effort to reestablish intimacy with me by presenting me with her successful experience on the trip and its painful loss upon her return.

I could therefore add the following comment to the patient at this point: "I now hear you describing your anguish at losing your newly established intimacy with Mr. T, and your effort to regain it here with me after a few days of absence."

"I don't even want to be here right now!" she interrupted.

"Of course not," I agreed, "if you won't be heard, and feel that I treat you with a formula, not even listening or appreciating how difficult it is to talk about these feelings."

"You know"—she now sounded much calmer—"feelings, especially painful feelings, could never be discussed at home when I was young. I've told you that many times. I am so sensitive when you don't hear them, or dismiss them casually as you just did. My father used to do that . . . ," and she gave several actual instances of when and how this had happened.

Only after the session was over did I realize that the more fundamental reason for my at first missing her effort to regain intimacy with me was my then still preconscious fear of the intensity and noisiness of her demands in relation to me. To the patient, I repeated her father's inability to respond to her demands for attention and affection in letting her work beside him in his tool shop, to enjoy the intimacy of a tête-à-tête while learning his skills.

Although such countertransference intrusions are often responsible for the analyst's turn to a dynamic formula, they are not the only reason for this. More often than not, such a shift occurs when the analyst aims to elucidate a maladaptive mechanism in the patient's behavior; or when such dynamic formulas are used mainly in the service of laying bare the mechanism of psychopathology, of which the analyst may miss the more

crucial transference message of the moment. In the case of Mrs. A, this had to do with her wish to reestablish her sense of intimacy with me, since after all, the sharing of her experience with Mr. T occurred in the service of reestablishing intimacy in the analysis. The patient alluded to the genetic significance of this longing: she wanted to re-create the tool shop milieu of her childhood with her father—the location of experiences that I knew had been traumatic to her, because he had never permitted her to participate in his work. She hoped that this time around, here with me, such an experience would be possible.

CONCLUDING REMARKS

Our objective in this essay has been twofold: (1) to demonstrate the manner in which we use the clinical theory of self psychology, that is, selfobject transferences and the two steps of the interpretive process—understanding and explaining—as a guide in conducting analysis; and (2) to describe and illustrate the close relation between the clinical theory of self psychology and the treatment approach correlated with it.

We are aware that only a limited aspect of the treatment process can be illustrated by such samples. However, we hope that we have been able to convey the essence of our approach, the central features of our way of conducting an analysis, as guided by self psychology. In these concluding remarks, we will expand somewhat on what we were able to illustrate directly with our clinical vignettes.

Patients with mild or severe self-pathology ubiquitously search for certain experiences in their everyday lives, and in so doing, use other people—in either barely noticeable or in blatantly obvious ways—to obtain what they were never able to elicit spontaneously from their early selfobject milieu. On entering analysis, such a patient struggles against a mounting reluctance to establish his or her deficit-specific selfobject transference. This reluctance is fueled by the patient's fear of retraumatization in the analytic situation, and/or shame over infantile

needs—creating the well-known resistance (Kohut 1984). It may also happen that this phase of reluctance and shame is short-lived, and that the patient is then able to mobilize his or her transference expectations and direct them explicitly toward the analyst. In the case of the former, the interpretive process is centered on acknowledging the difficulty in trusting the analyst in the light of earlier traumata, and on making sense of the patient's caution and fear of retraumatization. This will ultimately engender increasing trust, followed by a progressive expression of hitherto unmet needs. In the case of the latter, the interpretive process is centered on the recognition that the intensity of the patient's needs are understandable in light of his or her traumatic experiences of never having felt seen, admired, or valued and affirmed. As part of this process, in either case, the patient's exacting needs to acquire or extract belatedly what he or she missed in infancy or childhood will dominate the analytic experience.

The two dreams of Mr. G in our first clinical example depict this state of affairs clearly. So do the memories of Mrs. A, evoked by her experience of the disruption of the transference. In both these analyses, the mirror transference continued to function as the frame within which the patient's experience in the analysis and in his or her life outside, as well as historically in infancy and childhood, could best be illuminated and the deficits substantially ameliorated.

The vignettes from the analysis of Mrs. A also demonstrate how certain disruptions and their repair deepened the analysis by allowing us to recognize specific deficits and their consequences in the patient's personality structure and behavior. Here it was especially poignant that an unempathic response (the analyst's failure to listen to her carefully enough, instead giving her a "bookish" response) brought back memories of her early experiences with her mother (having been disregarded, shut out by her), which had left the patient with the specific vulnerability laid bare by this and other disruptions. Some such disruptions are inevitable and will occur even under the most felicitous circumstances. But there are others that can be avoided by changes in the analyst's approach. This may be aided by a theory

that invites the analyst's imaginative entry into the inner life of the patient via empathy, thus leading to an understanding of the patient's subjective experience.

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MARCELLA: THE TRANSITION FROM EXPLOSIVE SENSORIALITY TO THE ABILITY TO THINK

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The author discusses an analytic case in which it was necessary to first address the patient's need for containment of her protoemotions—her sensoriality—before the analysis could proceed along more standard lines, with interpretation of the transference, work on displacement and aspects of her childhood history, and so forth. Prior to treatment, the patient had resorted to a sort of affective autism in order not to experience dangerously overwhelming emotions, and her emotional lethargy in sessions at first engendered similar feelings in the analyst, making progress impossible until a container was established for her projective identifications.

INTRODUCTION

With some patients, a lengthy portion of the analysis must consist of the patient's consent to, and cooperation in, the development of the capacity to think by building a "place" in which to "hold" not only his or her emotions, but also the analyst's interpretations. This task must be accomplished before one can work with displacement and on the reconstruction of childhood history, using classical interpretations.

In the case I shall present here, that of Marcella, the pivotal part of the analysis consisted of this work that I would define generally as the establishment of containments. This aspect of the analysis took priority over its actual content, since it provided the

opportunity for a transformation to take place—a transformation of Marcella's turbulent protoemotions and whirling sensoriality into emotions and thoughts that she could begin to manage as they took shape in her psyche. As long as she was not able to do this (a situation Bion [1962] might have defined as a lack of the alpha function and of the container), her psychic activity consisted either of continuous evacuation, or of a deep drowsiness—a sort of hibernation of her protoemotional states and an emotional and existential deadening. These ways of functioning served as a sort of emotional leveling that impeded the formation of protoemotional states, which the patient would have experienced as a source of danger because she could not contain them; she did not know how to transform them into experienceable emotions or thinkable thoughts.

It has taken me a long time to organize my thoughts on the work I have done and which remains to be done with Marcella. In such cases, when clinical work becomes bleak and obscure, when the patient's maladaptive patterns of psychic functioning appear unmodifiable, and when there is no visible means of exit, I have found it necessary to rely on all the patience I can muster. Many of the major steps I describe in my work with Marcella took on special significance only after the fact. Furthermore, a primary feature of the analysis was my own mental functioning in sessions; for a long time, it was necessary for me to compensate for the patient's inability to live her own emotions and thoughts, until I gradually managed to pass on this skill so that Marcella could do it for herself.

BIONIAN FOUNDATIONS

Much of my formulation and discussion of the case of Marcella derives from the conceptualizations of Bion (1962, 1963, 1965). For Bion, the work done by the mind of the mother (or the analyst) on the feelings of anguish, or beta elements, that come to be projected onto the child (or onto the patient) is central. If such feelings find a mental receptor—of which the capacity for reverie

is one factor—they can be transformed into alpha elements, attesting to the success of the process of thought formation (or in another language, one might call this the process of symbolization). The repetition of the projection of beta elements, their reception, and their restitution after having been transformed into images (to use an alternative vocabulary, through a process of imagination and representation) together lay the foundation of the development of what Bion called the container. It might be thought of as a sort of "basket" that serves to give a place for emotions and thoughts, so that they can develop and become interwoven into the individual's psyche.

Bion's conception of the mind might be likened to that of a digestive apparatus that must be developed in order for it to be able to digest sensorial input, since that which comes to be digested will form the elements of the basis of thought. Furthermore, Bion considered the process of projective identification to be an action having the purpose of communication, and that it also has the function of projecting sensoriality that comes to be transformed into useful elements for thought (Ferro 2002a).

Marcella's analysis could be seen as a lengthy labor in the service of constructing such a digestive apparatus, before work could proceed on the contents of the apparatus. I will try now to describe the significant phases of that work, some of which I was able to make sense of only after the fact, and only after undergoing laborious countertransferential examination.

EMOTIONAL TURBULENCE: FROM PROJECTIVE IDENTIFICATION TO NARRATION

Marcella's "Apartment Below"

For a long time, the main feature of my sessions with Marcella, a young woman who worked as an office clerk, was boredom—an atmosphere of boredom that seemed gradually to fill the room and to take over my mind. Physically, Marcella was neither pretty

nor ugly, and intellectually, she had no interests whatsoever: nothing attracted her or got her involved. She had come to analysis because of an undefined and indefinable state of malaise.

Very soon, I started to perceive the work with her as heavy going and boring, and I found myself unable to make interpretations in the transference, almost as though I did not want to "touch" her. I noticed that once I had been listening to her for a while, my thoughts seemed to become disconnected; I tended to lose contact and would stop following even the manifest level of what she was saying.

This all changed when Marcella told me about a dream. In it, she was opening the drawers of a chest near her bed, and they were full of spools of thread, all different colors mixed together. She shut the drawers quickly, frightened by the idea of how hard it would be and how much patience she would need to sort out all those tangles. In associating to the dream, Marcella remembered that as a child, she used to play at the home of her grandmother, who was a seamstress. But my mind suddenly lit up with the idea of another meaning of the Italian word for a spool of thread, *spoletta:* it also signifies a fuse, of the type used to ignite explosives. This thought immediately reminded me of a child I had had in analysis who used to cover pictures of fierce animals that frightened him with a thick layer of Plasticine, and I suddenly understood why for so long I had not been able to reach Marcella on an emotive level with my interpretations: it was because I was afraid she would "explode." At that point, I was able to transfer with the patient to her grandmother's workroom, and to uncover her terror of the tangled, explosive emotions she had kept shut away in drawers by means of her boredom.

The "spools" started to unwind as Marcella's "stories." However, I felt that these stories could not be interpreted in any way, either in their real sense or in the transference, and that there was not even any point in trying to do so because we were immersed in a concrete setting. I therefore focused on the manifest level of the narration, sharing what Marcella had to say and trying to make my interpretations highly "unsaturated" (Ferro 1996a,

2002b)—that is, tentative rather than conviction driven. Above all, I had to recover my ability to think—which, when I was with Marcella, tended to dissolve, leaving me confused, disoriented, and unable to make meaningful connections.

I recall a period during which renovations in the apartment below my office, which had been ongoing for a long time, started to assume significance in our work together, and Marcella began to nose around that floor of the building. This was the point at which I realized that two levels of communication were taking place between us: one superficial—totally shallow—and another carried out via projective identifications, which had the effect of numbing my ability to listen even to the manifest text of her speech during sessions. As mentioned, these projective identifications seemed to disconnect my own thought processes, and made me aware of an undercurrent of protoemotions so absolutely primitive that they were either evacuated or became tangled up in boredom.

And so stories surged up from the apartment below. Marcella talked about the *pastina* on the walls, referring to the rough plaster mix used by the workmen. In response to a comment of mine, she added that *"pastina* on the walls" reminded her of a very angry child. It came out that she had had childhood tantrums when her soup, which contained tiny pieces of pasta *(pastina),* was not the right temperature for her, and she had chucked the whole plate at the nearest wall, splattering the contents. Here I recall my difficulty in agreeing to backdate the problem to her childhood, instead of finding an easy, straightforward relational explanation—for example, one relating to the way in which the patient reacted every time an interpretation seemed too hot or too cold, and how she liked to "splatter" the contents of interpretations.

The same was true of the Turkish divan that Marcella described having in her bedroom, which was something like a "bed with a backrest," bringing us back to the analyst's couch. This was not associated by the patient to certain aspects of herself that were foreign to her and whose language she did not understand,

but these meanings were not lost when perceiving her remarks from a field viewpoint (Baranger 1992; Ferro 1992). Such meanings are always present in the analyst's office if they are present in the analyst's mind, waiting either to turn into plots that can be shared, or to open up fresh space in which to permit new thoughts to become thinkable.

An Emotion Takes Shape

After a further period of analysis with Marcella, I started to feel that I was dealing with a sort of squid, the kind that shoots out ink when threatened. Every attempt to get closer to the patient or to make even the most cautious interpretation was met with a shower of "ink." The only resource I could use was my patience. This stance was eventually rewarded, as affective relationships gradually started to come to light in our workplace, alongside what Marcella called her "office connections"—stories about her work as an office clerk.

In one session, when I had managed to help establish a serene atmosphere with only minimal persecutory feeling, infantile memories began to surface. These included one memory—Marcella did not know whether she actually remembered it, or whether her mother had told her about it—in which she was in a sort of baby walker, in a long corridor with three doors opening off it. (It seems hardly necessary to point out that Marcella was coming to three sessions a week at that point.) In the memory, she was running faster and faster until she violently struck the wash basin in the bathroom at the end of the corridor. This tale brought our session to an end, and I felt pleased that this deeper, more personal level had finally started to emerge.

One day, in the ten-minute break I allow myself between one patient and the next, I was struck by a violent headache. I wondered why, since I do not usually suffer from headaches. I started to worry about how I would deal with my "new" patient in the next hour. I felt it had something to do with Marcella, and suddenly, I grasped the way in which my headache, the next hour,

and the "new" patient were all linked. A change had taken place in my work with Marcella—not in the sense of a massive identification with the patient, but rather a change that had been brought about by the arrival of a strong emotion, a mental pain, in the field. This psychic suffering would eventually allow a leap to occur in Marcella's mental growth. I could see only its precursor at that point, but once such a presence takes hold in the field, it is never long before the patient accepts it. It later became clear that the pain appeared in response to an upcoming weekend break, as well as to the break revealed when I told Marcella of my vacation dates. I feel it is significant that I was the one to *live* Marcella's first strong emotion, so to speak, and to receive it and organize it as a thought.

Some time afterward, Marcella arrived for her session a quarter of an hour late. She was normally punctual, even though she came from out of town, but on this occasion, she told me that her train had been delayed when the *controllore* (ticket collector) had seen a young drug addict lock himself in the toilet, and had tried to get him to come out and get off the train. The ticket collector finally managed to get the boy to disembark, but the boy then got back onto the train—whereupon all the train doors were locked, and only then had the boy been successfully sent away. The whole procedure had taken fifteen minutes.

A scholastic interpretation would have been easy to make ("it is a part of you that made sure you were late for the session —indicative of the extreme need you feel of analysis"), but I felt that such an interpretation would have come too much from me alone. It would have been in -K, as Bion (1965) might have put it, and it would not have fit the patient. Furthermore, this type of interpretation would not have produced insight, and might even have caused a sense of persecution in the patient and a resultant loss of contact.

Earlier, I mentioned my contribution to a serene atmosphere —but what exactly does that mean? Does the analyst pretend to agree with everything, or does he or she pretend that nothing has happened? I would say absolutely not to either question,

nor can the analyst be seen as simply testing the temperature and distance of interpretations (Meltzer 1976). I do believe, however, that it is essential to respect the patient's threshold for tolerating interpretations, and to recognize that a feeling of persecution in the session is a glaring sign of excessive insistence.

I asked Marcella to comment on the episode, telling me how she lived it. This prompted her to relate some childhood memories centering around her father's job. He had been a railway worker—in Italian, a *ferroviere*. (Notice that my name, Ferro, means *iron* in Italian, and that a railway is a *ferrovia*—literally, an iron way.) Railway workers, Marcella said, have to pay for delays that they cause. And serious problems occur when people attempt suicide by throwing themselves onto the tracks. She then started to talk about occupational hazards for workers in other fields, mentioning a psychotherapist friend who had been knifed by a patient. She carried on talking, until I asked her, "Is there some link between the dramatic events you are describing—suicides, knifings, and drug addiction—and the fact that I told you in the last session when I will be going on vacation?"

Marcella laughed, clearly relieved, and surprised me by replying, "If we no longer have only 'official' relations here, but also affective ones, then violent emotions, which are not always controllable, can come up." In that case, I pointed out, the ticket inspector *(controllore)* might just as well not have delayed the train with his attempt to block the desperation and anger hidden under the guise of the drug addict.

Dreaming of Red Peppers and Potatoes: Names for Emotions?

Marcella now talked less about what happened at her office, and when she did speak of it, she increasingly referred to the affects there. One day, she told me that a colleague at work had said she had been cured of her "affability complex," and Marcella herself proceeded to complain, getting angry about things she did not like. She wanted simpler, more immediate relations, she said, and then related a dream: she was meeting some friends and wanted

to bring them something to show how happy she was to see them and to have them as her guests. So she took a red pepper and a potato and ran to meet them. But two animals she did not know leapt out at her and shredded the vegetables, turning the pepper into a Chinese lantern.

I asked her what those animals might be, seeming as they did to foil her intentions and to prevent her joyful, immediate meeting with her friends. (Naturally, I resisted any transference interpretation, so as not to create a persecution factor that might impede our communication.) She replied, "They are what is left of the difficulties and fears I have had in relating with others"—and which, I added to Marcella, transform simple feelings, emotions that need a name, into strange, enigmatic things.

The "Folli-Cular" Tumor: A Fear of Strong Feelings

At this stage, I unexpectedly found myself going through another long period of hibernation, when a fresh bout of boredom seemed to freeze everything. I could work out what it was that was sending me to sleep: Marcella was using an absolutely monotonous voice to narrate things, just stringing her sentences together with "and . . . and . . . and," with no main or subordinate clauses to help distinguish the important communications from the less important ones. Any potential difference was masked by coordinates and more coordinates, all apparently grammatically equal. I was lost in this sea, lulled almost to sleep by the repetitive rhythm of the waves. Any attempt at interpreting—or even at describing—what was going on, after we had talked about emotions, was made in vain, until finally, something shocking happened. Marcella said: "My family doctor noticed a swelling on my neck and sent me for tests. A few days later, I was told I have a tumor with malignant cells."

This was the storm that whipped up the still sea. After a long string of medical investigations, it was determined that Marcella needed immediate surgery. I had to follow these communications, which were dramatic and urgent, by observing their outside

reality, but at the same time, I felt an increasing need to find the meaning of what was going on in the analytic relationship.

Marcella told me that she might have to have a thyroid lobe removed, and added that she could not tell her mother about it because she would have trouble coping. Marcella added that the doctors did not yet know whether it was a papilliferous tumor or one of a "folli-cular" form. I felt at this point that an urgent operation was needed in the analysis, too, and I told Marcella that for some time, I had in fact been wondering whether she might have something in her throat—something that she could not get out, a highly malignant thing, maybe a folly, and that there was something she felt she could not mention to me for fear I would not know how to deal with it.

Marcella seemed at first to hold her breath, but then, in a frightened voice, admitted that there was indeed something she had never dared to tell me in all these years—which was in fact the real reason why she had decided to start analysis, even though she believed she would never be able to talk about it. She was terrified of being thought mad, she explained, but there was no longer any question about it: her house was haunted. Each time she left the house, there was a little ghost of a child at the window, who waited for her when she returned, and it wandered around the house and watched her. Sometimes it played tricks on her, but it was actually harmless, and in fact kept her company. There were other ghosts, too, not clearly identifiable, who were playful; sometimes Marcella would find that they had prepared food, or tidied up the house, or had hidden something in order to make her play at finding it. Sometimes they played tricks on her, too.

I must confess that this account left me speechless, and I could only conclude that Marcella's deep loneliness was relieved by these "presences," which would surely come to have some meaning in her analysis. She then went on to tell me that she was afraid she was a witch because she had supernatural powers, in that she could foretell the future, and could call down good things and curses. All of a sudden, she asked me whether these

were hallucinations. I told her that I thought they were more like daydreams—ones that had every right to exist.

This exchange initiated a series of sessions during which I discovered Marcella's world of ghosts, and my reaction was to tread fearfully among them. Sometimes, I had the sensation that the patient was frankly delirious, but there were also moments when I felt that she and I were playing games. In any event, we could at least begin to find a shared meaning: was I, too, from a certain viewpoint, just another little ghost in the patient's life, with my own significance—a presence who tidied things up, prepared meals, and waited for her? I reached the point of asking myself this only after numerous sessions in which we simply "toyed" with these little ghosts—while I inwardly trembled with fear.

I should add that I have had considerable experience with patients who suffered from hallucinations (Ferro 1993) or who had visual "flashes" (Ferro 1996b). But these patients all showed fear, disorientation, anxiety, stupor, and a lack of explanation—or at least of curiosity—about the things they "saw." I had never had a patient who talked quite normally about her ghosts and her relations with them, while at the same time expressing doubts about her sanity.

Help came to me in the form of a play I remembered, one by the Neapolitan author Eduardo de Filippo. In *Questi Fantasmi* ("These Ghosts"), the main character interacts with the "presences" living in his house, which he believes, quite naturally, are ghosts with whom he can establish significant relations.

At this stage of the analysis, Marcella was operated on. The histological examination showed that she did not have a follicular tumor, but a papilliferous one. She was obviously relieved, explaining her understanding that the former was very serious —a "cold" nodule—whereas the latter was a "hot" nodule. This brought us to the subject of passion, and Marcella explained that she considered the bureaucracy of her rather mundane office job to be one way of walking on the hot coals of passion. The ghosts also represented something hot and exciting, even though they

sometimes seemed encysted; they were not cold or paranoid things. And here, I must admit, I worried that Marcella's fiery temperament might flare up before the discussion of the ghosts was fully unraveled.

The Ghosts

I had trouble working with these ghosts, since I felt that I was balancing on a tightrope, poised between an inability to convincingly reassure the patient that they *did* exist, and the impossibility of interpreting them exclusively as detached objects or functions. For a long time, drawing on my experience in analyzing children, I resorted to playing with these presences without defining them (Ferro 1996c). I gave them a place to live, hoping that, as we gathered together the emotions from which they were woven, they would eventually be free to present themselves without having to be clothed in this sort of fantastic exterior substance.

Marcella and I had been in this transitional area for a while, in which the characters moved around and interacted, and I began to realize that it was possible to reach the emotions they externalized, regardless of whether they were dream flashes or hallucinatory transformations. Then, at the beginning of a session, Marcella told me by roundabout routes that she had one of her grandfather's pictures in her home; it was a painting she particularly liked, of a landscape containing a tree, a child, and some elves *(folletti* in Italian). When she had finished telling me about the picture, I found the strength to ask her: "And what has become of the ghosts?" As if it were the most natural thing in the world, she answered, "Oh, they've gone back into the painting."

Once the ghosts had been metabolized and returned back into the painting, a miracle took place: no more boredom, no more drowsiness. Lively emotions came to light—bordering on violent ones, and on the theme of "there's no room for me." This took us back to the patient's childhood and the fact that, although the family home had enough rooms, she was not given one of her own, but had to sleep on a foldaway couch in the liv-

ing room—a situation similar to the precariousness of my office couch, which also is not really hers. She mentioned her mother, who had room for her own hypochondriacal anxiety, but not for her daughter's worries and projects.

The Padded Cell

As had been her pattern since the beginning of the analysis, Marcella reacted violently every time that a session had to be skipped: this was tangible proof that there was no room for her, and she laid on a temper tantrum and a display of desperation. This return to life also passed through a reverie of mine, when she said that she felt she was throwing herself against a "wall of rubber," but no one was answering; this reminded me of padded cells in old mental hospitals. When I told her this, she was struck by the imagery, and she was moved: her emotions could only be put to sleep, or contained, in a padded room for violent patients. For a long time, her bureaucratic office job had served as this padded room—deadening everything, absorbing anything that might become too violent. Subsequently, she dreamed of Zulu warriors, which frightened her, but which also confirmed that her primitive emotions were no longer bottled up. She was not beating against a rubber wall any longer, so her emotions could be let free, even if she was afraid of them.

After the next skipped session, Marcella told me of a dream that her house keys had been broken, and she had felt an anxiety stronger than any she had ever known—a kind of "black anguish." "As black as the Zulus," I suggested.

Corn or Chocolate

For several months, Marcella and I worked to contain and transform the Zulus, and Marcella's autistic defenses—which had the function of deadening everything—gradually became less evident (Klein 1980). During this period, the patient told me about another dream: she went into a room where someone was try-

ing to spray a deodorant, in order to get rid of the smell of something related to the handle of a toilet in the next room. Then she touched a navy blue coat and "flakes" formed on it; when she tried to brush them away, they initially flew off, but then drifted back onto the coat. They were like cornflakes or chocolate flakes.

I was at a loss here, so I asked the patient what she thought of the dream. Marcella replied that the flakes made her think of something that *wanted* to get free but that kept coming back to its place, something to do with relations with other people. This comment lent credence to my experience with the patient, and I told her that when we met, something at first seemed to close up, after which we could remove the flakes and enjoy a good level of communication—but then we had to start all over again from the beginning.

"As if the gap were not forever," Marcella mused. "That's right," I replied, "but the flakes are made of corn or chocolate." "They're biodegradable, digestible," Marcella responded. These flakes, remnants of an old armor plating, could now be digested and brushed away, even if not yet forever.

I proposed that, in the first part of the dream, the deodorant was meant as a way to avoid tackling unpleasantness. Marcella agreed, and started off on a topic she had always tended to drop: her feeling that she was not wanted, that people just put up with her—and also that her femininity had never been fully acknowledged. I took this as a signal that an inner space (container) had opened up inside her, and that I could now begin to reach her with interpretations of transference, with no longer any need to fear emotional explosions or the development of persecutory ideas. Now, in fact, the interpretations seemed to be expected, desired, and to serve as the source of further transformational potential.

A Sexual Relation between Minds

My methods of interpretation with Marcella have changed, and I now interpret what happens in our relationship and her

inner world and story in a much more intimate fashion, no longer worrying about intrusion or a sense of persecution in transference interpretations. In this new environment, Marcella related another dream: She was on a couch with a young man who kissed her neck and started to unbutton her blouse. She wanted him, and told him to stroke her breast; his touch became more intimate. This dream, beneath its eroticism, seemed to indicate her desire to gradually make even closer contact with me, and the pleasure of the meeting seemed to confirm the patient's new way of functioning in analysis, as well as the greater accessibility of her own emotions and thoughts (Ferro 2000).

In another dream, Marcella was making love with David, a dear friend, and in another, with a homeless woman who had at last found somewhere to stay. Finally, there was a dream that seemed to indicate what she wanted from analysis, in which she went to a jeweler and asked for a ring and a cameo with an angel's head. She commented on this herself in describing the dream, saying that what she really wanted was a husband and a child. But I suspect that she also wants a more stable relation with her analyst, a more fertile meeting of our minds, since all her previous relations—starting from the one with her hypochondriacal, depressed mother—had been sources of nothing but disappointment and distress.

CONCLUDING REFLECTIONS

The journey with Marcella has not yet ended as I write these pages; there is still a road to be traveled. The analysis up until this point, however, illustrates my belief that, concealed in the interpretive activity, there may always be torment in the mind of the analyst (Ogden 1997), which becomes a receptor, an assumption of anguished feelings, of the protoemotional states of the patient (beta elements) that it must absorb, metabolizing toward the real capacity—often not conscious—of transformative elaboration. Interpretations thus become a way of giving testimony and

a sense of emergence to this silent and complex work, which has much to do with the mental characteristics of the analyst and with his or her subjectivity (Renik 1993), which I believe comes more into play when the patient's situation is more serious (Brenman-Pick 1985).

It may be useful, perhaps, to continue here the alimentary metaphor mentioned earlier. The patient might be seen as bringing certain "raw" emotions to the analysis—emotions that are often violent and not manageable with his or her own cooking equipment, with the aim of "cooking" these into more cohesive thoughts and emotions. The analyst is called upon to put at the patient's disposal the appropriate mental kitchen apparatus: pots, pans, and oven, which will not only be utilized by the patient, but which will also, through repetition of their use, permit—when things function fairly well—a progressive introjection of such cooking apparatus into his or her usual equipment at hand. Thus, the cooking implements, and consequently the ability to cook, which were originally supplied by the analyst, eventually become the mental inheritance of the patient.

This metaphor also permits us to distinguish the work done by the analyst in the "kitchen department" (how much the analyst elaborates in his or her mind) from how much the analyst brings to the table in the "restaurant department"—that which the analyst communicates to the patient with actual interpretations. Because of this, I believe that the analyst's interpretative style must be flexible—adjustable to the digestive capacity of the patient, in a manner that interpretations may function as factors of growth and not of persecution (Ferro 1996a, 2002b; Guignard 1996).

With Marcella, long and silent labor has been necessary, conducted in my "kitchen department," before the psychic areas that were devoid of the capacity to live emotions could be elaborated and transformed. For a long time, she had used a sort of autistic nuclei as defensive armor that protected her from every excess of feeling that she did not know how to metabolize in thought (Tustin 1990). Marcella had to develop her own alpha functions

in order to manage her protoemotions, rather than merely resorting to evacuation—that is, to turning her protoemotions into hallucinations, her ghosts. She accomplished this through repeated microexperiences of being in unison, of engaging in emotional sharing (Bion 1962, 1963, 1965). Now that she has reached that stage, analysis can proceed along the rails of a mind that is adequately mapped. Thus, analytic work on the displacement and reconstruction of the infantile experience can take center stage. I would like to again emphasize—this time with a Freudian metaphor—that it is necessary with some patients to reconstruct the magic "notes" before being able to see in them what must be displaced.

In this essay, I have chosen to present a narration focused on the development of the transference-countertransference axis in the analytic work, in order to give coherence to my presentation and to limit its overall length. Inevitably, other stories and other characters, viewed from alternative vantage points, could also have been described, and would permit a more complete view of the work done with this patient.

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BACK TO THE FUTURE

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Significant components of psychoanalytic technique, and the theory that underlies it, seem to remain buried in our past, but are central to the growth of psychoanalysis as a treatment method based on understanding a patient's mind. By updating technique based on a theory of mind with structure, the author views the increasing freedom of the patient's mind as central to the curative process, and takes the position that in interpretive work, the analyst needs to pay more attention to the patient's capacity to meaningfully receive and integrate the analyst's interventions.

INTRODUCTION

Every psychoanalyst has a theory, articulated or not, that governs everything he or she does in psychoanalysis with every patient. This theory encompasses the smallest detail, such as how we think about silence, as well as larger issues, such as what is curative in the analytic process. Based on a bedrock principle of psychoanalysis that it is what we do not know about ourselves that gets us into difficulty, I believe it is incumbent upon us to be as articulate as possible about our theory of technique. Yet it is my impression that it is very difficult to get analysts to talk about technique. In sharing case material, we quickly move to talking about the meaning of content, while it is a struggle to get a discussion going about technique that is not a disguised form of supervision.

In writing this, I have struggled between the wish to summarize previously elaborated theoretical positions that inform my clinical work, and the desire to present newer views that I am currently developing. I have ended up trying to do a little of both, looking back (in the theoretical section) and looking forward (in the clinical case presentation).

APPLICATION OF THEORY TO CLINICAL WORK

It has been my premise that certain areas that have been central to the theory of clinical technique are increasingly absent from clinical work, much to the detriment of our capacity to help individuals via understanding. If we are to consider analysis a method that, in the main, is different than other forms of treatment —in that we help patients via an understanding of their minds and of the role the mind plays in psychological functioning—then certain methods based on a *theory* of how the mind works seem central.

My clinical work is based in part on three basic premises from the Structural Model. The first is that the mind is built up by structures. The second is that there is a specific structure in the mind that mediates between the internal pressures from preconscious and unconscious thoughts, fantasies, affects, and so on (with their own conflicting forces), and the demands and pleasures of the external world. This mediator has been labeled the *ego,* and for heuristic purposes, it seems useful to keep this term. The third premise is that the basis of neurotic and character symptoms is unconscious fear. This view is inherent in every major theoretical persuasion, although the causative factors are understood differently.

In a condensed form, I will describe how this sketch of theory translates into clinical practice.[1] A key aspect of analytic treat-

[1] For further elaboration, see Busch 1992, 1993, 1994, 1995a, 1995b, 1996, 1997, 1999, 2000, 2001.

ment is to make unconscious fears not so fearful, and to allow the possibility of reflection to replace the inevitability of enactments. This results in a decrease in symptoms. Every analyst since Freud has found that this is not so easy, as these fears are unconscious and based on old adaptations that have led to a complex worldview to protect and gratify. Central resistances to change are found in the work of the unconscious ego. Therefore, successfully working through resistances depends upon bringing the machinations of the unconscious ego into awareness.

As part of the working through of unconscious resistances, we discover old microstructures (of fantasies and feelings) that are symptom related. With understanding, new microstructures are formed, while macrostructure building also takes place (that is, a widening of the ego's capacity to think and feel).

FREE ASSOCIATION

The method of free association serves as an important technique for working within my basic model. First of all, it is the ideal way for both the *patient* and the analyst to observe unconscious fears expressed in the immediacy of the analytic situation (see Gray's 1982, 1986, 1994 work on close process monitoring). This belief is based on our conception that one major role of the unconscious ego consists in recognizing and responding to unconscious fears, which it does by withdrawing from frightening content in order to protect itself from overwhelming anxiety. Thus, the ego functions as an *intrapsychic* mediator, as well as meeting the demands of the internal and external world. Since the ego responds to an unconscious fear with an emergency measure, we rely on another part of the ego[2] to take in our invitation to observe with us what has just happened. It is the piece-by-piece enlargement of the capacity for observation that is our main ally in the midst of the transference neurosis, and a significant part of the curative process (Busch 1999, 2000).

[2] Topographically, the preconscious or conscious ego, and structurally, the higher-level ego functions.

THE EGO'S CAPACITY FOR OBSERVATION

In order to facilitate this curative process, therefore, I strive to make interpretations that are based on the *ego's capacity for observation.* This is a continually changing process, one that leads us to interpret in a variety of ways. Interpretive use of other sources of analytic information (e.g., the analyst's countertransference) are most effectively synthesized by the patient if an attempt is made to integrate them with what is most observable by the patient using the method of free association (Busch 1998). This brings me to my concept of interpreting "in the neighborhood" (Busch 1993).[3] It is based on the premise that interpretations are most effective if the patient is able to make a connection between what he/she is saying or thinking preconsciously and the analyst's interventions. In listening to discussions of clinical process, one is impressed with how many interpretations seem to be based less on what the patient is capable of hearing, and more on what the analyst is capable of understanding. This leads me to another significant element in considering our methods of interpretation: the preoperational nature of patients' thinking in the midst of conflict (Busch 1995b). We have significantly underestimated the concreticity of patients' thoughts in the midst of conflict, often leading us to make interpretations at a more abstract level than is consistent with patients' capacities for conceptualization.

Closely following the patient's associations is an effective method for exploring with the patient what is on his/her mind, with the patient as his/her own *baseline.* This is most vividly demonstrated in intrasystemic and transference resistances. For example, if a patient comes in talking in a free manner, and suddenly becomes more inhibited in his/her way of speaking, we can observe that something has happened. In this context, the baseline has been the patient's previous way of associating. This baseline has many implications for the clinical moment, and can also

[3] See also Levy and Inderbitzin (1990) and Paniagua (1991).

be an indicator of analytic progress. The freedom to use the method of free association becomes one indication of analytic improvement (Kris 1982). Furthermore, closely following the *content* of the patient's associations allows us to work within an experience-near model of conflict resolution, as mediated through the ego. This represents a view of the patient's free associations as an unfolding of the unconscious sides of inner life, which, without undue influence by the analyst, will express the various components of the conflicts that have led the patient into treatment (Busch 1997). From our understanding of the *content and rhythm* of the patient's associations, and our own reactions to these, we are also more able to sense when the patient's thoughts are enactments, and when our countertransference becomes an invaluable guide in our understanding.

All of psychoanalytic technique is guided by the premise that the curative process lies in increasing patients' freedom to think, feel, and express themselves via the methods outlined above. The corollary to this is that we increase patients' degrees of freedom by increasing reflection where there has been a tendency to enact (Busch 1999, 2000, 2001). Action without reflection is hardly inevitable.

CLINICAL MATERIAL

Case Background

Aaron was a lawyer in his forties who came for treatment after experiencing professional setbacks, increasing anxiety at work, and feelings of distance from his wife. Aaron had done extremely well in law school and had clerked at a prestigious law firm. He was offered a position at this firm upon graduation, but chose instead to work at legal aid. Consciously, Aaron saw this decision as based on philosophical principles revolving around his social conscience and ambivalence over the money-driven culture of large law firms.

After a number of years and a growing family, Aaron felt he needed more financial security, and reentered the world of pres-

tigious law firms. He was able to do this on the strength of the many articles he had contributed to the literature during the time he was in legal aid. Over the years, he had become part of the intellectual brain trust of the firm he joined. However, as he rose toward a leadership role, he became increasingly ineffective. His colleagues helped him to see how he kept shooting himself in the foot. Meanwhile, he started to have severe anxiety attacks when presenting at national meetings.

Aaron was a handsome man who nevertheless managed to draw critical attention to himself. I found myself thinking things like, "He's wearing the wrong tie with that suit," or "The style of his shoes doesn't match the rest of his outfit." (Fashion reviews are not typically a part of my clinical thinking.) Aaron's manner when he began the sessions was obsessional, deferential, and self-critical. This eventually changed, although I sometimes still felt that his ties were all wrong. The session to be reported is from the twentieth month of a four-times-per-week analysis.

Session Synopsis

Aaron began the session in an enthusiastic manner. The overt feeling in the air was that something important had happened and that he was able to recognize it as a notable psychological event—one of the first times this had occurred in the analysis. At times during the session, I found myself feeling like the proud mentor of a gifted student. He began:

> Something happened today that was really interesting. One of the law clerks I've mentored for two summers, Ann, is very attractive. She has a clear, concise mind. Ann and her husband come from the South, and want to return when she finishes law school. My mentor from Shreve and Crump[4] [where the patient did his clerkship], Ted, is now in Dallas. I've been speaking to him about Ann for a while, and he agreed to oversee her interviews

[4] A fictitious law firm.

with his Dallas firm this week. Ted is my age, but he went straight to Shreve and Crump from law school. He didn't have ambivalence about going into practice like I did. He's had a stellar career, most recently with this prestigious group in Dallas. When I was at Shreve and Crump, he was very supportive of my ideas, and I found that tremendously energizing and reassuring. He's very good at what he does.

Anyway, I had a three-way phone call today with Ann and Ted. Ann ran into a problem while interviewing with the Dallas firm. She's been working with me here in the area of intellectual property, and she hoped to continue her work with some of the partners in Dallas who seemed to have similar interests. However, as she's been talking to people, it's become clear that their interests are in somewhat different areas, and they told her that she shouldn't come to Dallas thinking she could continue with her interests.

I had realized that this might be a problem and counseled Ann about it. Yet I guess I wasn't able to be clear with her; I think I made it more muddled than it needed to be. I know many of the guys down there, and I thought, "They're my friends, of course they'll sponsor Ann's work." On the other hand, I thought she might just continue her work with me for a while, and then drift into something that's going on there. That's how I did it. However, Ted didn't think his firm could support this for Ann at this time.

Ted had so many good ideas about Ann's career. He's so good at what he does. I felt really exposed in front of Ann. It really threw me for a while. I came away thinking this was an event.

Until this moment, Aaron had seemed spontaneous and lively. He appeared to be full of the thoughts on his mind. However, at this moment, his thinking slowed down considerably, and for the next few minutes, he laboriously returned to aspects of what he had already talked about. We then went on to have the following exchange.

F. B.: I wonder if you noticed that your thoughts slowed down after you mentioned that "this was an event." It was as if something had stopped you at that moment from continuing with the same degree of spontaneity.

Aaron: Now that you mention it, I can see that. I don't know why I didn't say anything at the time, but I was thinking that this stuff with Ted might be the competitive thing you and I were talking about. Actually, Ted has become more of a managing-partner type, and isn't doing so much legal work any more. Most of his best creative work was done ten years ago. But he's really good at what he does. Whenever I speak to him, I feel like *he's the mentee and I'm the mentor.* He's accomplished so much more than I have. [He continued to talk about Ted's accomplishments.]

F. B.: When you said "he's the mentee and I'm the mentor," I couldn't tell if that's what you intended to say.

Aaron: Actually, I meant to say it the other way around, and I thought I had, but when I heard you say it back, I could hear my words. I guess that brings me back to my competitive side. Ted is really good at listening to briefs. People always come to him because he can see the essence of the argument. When Ted, Ann, and I were talking, she could see who was the boss.

F. B.: After you notice your competitive side with Ted, you immediately sing Ted's praises while putting yourself down, as if being aware of your competitive side makes you uncomfortable.

Aaron: Hmm . . . that's interesting. I find myself thinking about what kind of relationship I'll have with Ann

after she leaves. After I finished my clerkship at Shreve and Crump, I would return for their Wednesday meetings, where people brought up particularly interesting or difficult cases. After a while, Ted said that I couldn't attend, as the meeting was intended just for current employees and clerks. He did it in a really nice way. He's so good at that. [pause] I'm thinking about what an attractive person Ann is. It's not like I'm thinking about it all the time. [He went on at length about Ann's competence.]

F. B.: You seem to be trying to convince me that you really don't think too much about how attractive Ann is. From what you say, it seems you have a concern in the background that if these thoughts come to light, you'll be kicked out.

AARON: I'm thinking about the other partner at my firm who works in my area, Bob. I showed him this brief I was preparing. I felt it was very strong. His response was that it was "pretty good." He wanted me to leave out the section that I thought gave it real sex appeal . . . . Something else comes to mind. How much time do we have left?

F. B.: As you're thinking about this sexy stuff, you suddenly wonder how much time we have left.

AARON: I was thinking that we're probably out of time, but I hoped we had more time as I wanted to say something else.

F. B.: It seems as though you're wondering if I can accept your sexual thoughts, or whether I'll tell you that you have to leave the meeting.

AARON: For some reason, I feel compelled to tell you this. For a long time, I've had the feeling that I'm not good at sex. The first time I had sex was with a

woman named Sarah. She didn't have an orgasm. I felt my penis wasn't big enough.

F. B.: As I brought in your conflict over telling me about your sexual thoughts, you noticed that you felt compelled to tell me of feeling sexually inadequate. It's as if you needed to assure me that when it comes to sex, you aren't anything much.

AARON: In fact, it was very different with Virginia [his next girlfriend]. Her vagina was really tight. It was like Sarah was a superwoman; her vagina was huge. She could take in anything. I just felt so small and little next to her. Is that the same thing? [He laughs.] Or is my asking you that question the same thing?

Case Discussion

As a way of highlighting how my theoretical beliefs inform my clinical work, I will go through the session just described in some detail. The first issue to notice is that Aaron took a significant step in the treatment when he could see what was occurring in his life as a psychological event. This is the beginning of a necessary move in analysis from seeing oneself as only a victim of circumstances to the view of oneself as an active participant in one's own experience, in a nondepressive manner. As analysts, we need to be empathic with what has happened to our patients in the past, but it is even more crucial that we work through the internal meanings these events have for them. In the context of what followed in Aaron's session, it is not surprising that I ended up experiencing the patient's accomplishment as that of a gifted student.

Aaron then introduced his attractive law clerk, Ann, whom he had not mentioned before. We saw his struggle to freely experience and express to me his sexual desire toward her, and how he pulled back from this. The word *attractive* captures well what Aaron was capable of at that moment. He hinted at being sexually

attracted to her, but presented this via a generic term, *attractive,* that can mean almost anything. He then shifted farther away from any sexual connotation by telling me that he was really impressed with her mind.

Although we can see a defense in action here, Aaron was in the midst of telling me something *he had noticed.* To bring to his attention what *I had noticed* would be to enact my taking the more senior, dominant role. His retreat from competition to taking a secondary role was part of what he had come into treatment about. It was one of the moments when close process monitoring needs to be used judiciously in the context of multiple factors occurring at any clinical moment. Furthermore, it was a time when the significance of the method of free association must take precedence over the method of resistance analysis, as Aaron had just begun to tell his story via his associations.

In this context, I think we often fail to pay enough attention to the patient's capacity to talk through resistances. Resistances are not present or absent, but rather have different levels of crust, leading to variations in the degree to which it is important to speak to them. From another perspective, we can see that Aaron was *defensive.* Whether this would lead to a *resistance* was difficult to know at the time. In general, our analytic work is more effective when we interpret resistances rather than defenses.

The second character to be introduced in this session was Aaron's previous mentor, Ted, with whom Aaron unfavorably compared himself. The sexual nature of the comparison was expressed in Aaron's feeling that he was being exposed as inadequate in front of Ann, a compromise formation. In the midst of the session, we saw a sudden change of voice, in which Aaron's associations were no longer spontaneous, and the content became a dried-up version of what had already been discussed. At this point, the resistance was palpable and needed to be spoken to. The question was one of how to do this.

I believe, when possible, it is most useful for the analytic process to start by bringing the patient back to the moment when the

resistance occurred, to see what the patient can tell us about it. In this way, we are relying on the patient's thoughts as much as possible, and not speculating about what is on the patient's mind. The patient will tell us which aspect of the resistance he/she will be able to approach, if any. Furthermore, we want to stay as close as possible to an association-based method of intervention, in that it is the use of this method, I believe, that is the sine qua non of ongoing self-analysis. Thus, I brought Aaron back to the moment when the change occurred in his voice, i.e., with his statement that "I came away thinking this was an event." I pointed out that something significant happened at that moment, which changed the whole course of the content and manner of how Aaron talked with me. However, I started out with a question, "I wonder if you noticed . . . ?" I do this as a matter of course because, if the patient has not noticed or cannot recapture the change in voice, the analysis of the resistance becomes distant from the patient's experience, making the process too intellectualized, or implying that I am asking the patient to accept my observation on the basis of my authority.

Aaron then brought up that he was having thoughts of competitiveness with Ted, and expressed these in a variety of ways. He then made the unconscious slip of saying he was Ted's *mentor*, and when this was pointed out, he immediately returned to singing Ted's praises. This is an example of an unconscious conflict in action. Aaron was not aware that after his wish to be Ted's mentor came out in the slip, he had to negate this feeling. I then identified how the unconscious conflict had just been expressed. *The process of identifying unconscious conflict as expressed in the associative process is as important as identifying the unconscious fears and fantasies behind it. Until an unconscious conflict is brought to consciousness, the underlying meanings cannot be anchored in a new structure.*

At this point in my discussion, another important technical issue arises—around the interpretation of an intrapsychic conflict versus a transference conflict. That is, rather than interpreting the conflict, should I have interpreted it within the transference,

as the patient was negating his competitive side while talking to me? Many would say that this distinction is irrelevant, since the patient is always expressing intrapsychic conflict in the transference. While at one level, this may be true, the interpretation's meaningfulness to the patient depends on it being "in the neighborhood." I generally like to have available some associations to the transference that I can use as a link for the patient to be able to see it in operation, before interpreting the transference. This is why, even though my countertransference reaction to Aaron as my bright student would indicate that the whole session could be read as transference, interpreting this to Aaron in a way that would be meaningfully understandable to him would have been, in my judgment, impossible.

After I identified the conflict, Aaron's associations went to being kicked out of meetings if he acknowledged his sexual attraction to Ann. Again, I interpreted this unconscious fantasy underlying his fears in displacement. His associations then went to a male colleague who wanted him to leave out any sexy stuff from his work.

At this point, the transference was brought directly into the treatment as an enactment when Aaron asked, "How much time do we have left?" I took the unconscious meaning of this to be "Will you allow me to bring in this sexy stuff?" It was at this point that the transference became most approachable. Since Aaron had expressed an unconscious fantasy *within* the transference, I could now bring something concrete to his attention that might be more easily observable by him. It is instructive to compare this type of transference interpretation to a hypothesized one, like the one I declined making earlier. This one had a much greater potential to be experience-near for Aaron, thus allowing him to consciously grasp an unconscious process that is necessary for structure building.

When I interpreted his concerns over getting kicked out of the session for his sexual interest, Aaron's thoughts went to his sexual inadequacy. Different sides of Aaron's conflict were then expressed in the here and now of the session (e.g., "I am sexual-

ly inadequate," "What I have is so small compared to a woman," "Well, maybe it isn't, but maybe it is").

As the session ended, Aaron was able to identify his retreat from competitive feelings with me, and at the same time, he felt freer to express and experience his competitive feelings toward me. This freedom to know, to experience, and to reflect upon what was previously unknowable and unavailable to experience is what I see as the unique offering of psychoanalysis. It is this freedom that is curative.

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ANALYSTS' OBSERVING-PARTICIPATION WITH THEORY

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The author summarizes some of the literature's critiques of psychoanalytic theory, which have noted its constrictive quality and failure to take into account the vicissitudes of treatment within each analytic dyad. Such postmodern reactions have given rise to a countertheoretical trend toward psychoanalytic pluralism, leading the author to suggest that a single, standard psychoanalytic technique no longer exists. The interpersonal tradition, which tends to prioritize praxis over theory, is discussed in the light of its emphasis on an intersubjective model of participant-observation, and two clinical vignettes are presented to illustrate the author's way of utilizing this model.

INTRODUCTION

Early in the development of the psychoanalytic profession, Ferenczi and Rank (1924) sharply criticized clinical psychoanalysis for becoming excessively dominated by general theory, severely compromising the understanding of the unique individuality of each patient and each dyad. Especially in psychoanalytic writing, it was hard to distinguish one patient from another. Virtually every patient seemed to have the same underlying dynamics or internal structures, discussion confirmed the universal theoretical constructs of the day, and analysts' interpretations and verbal

interventions often sounded stereotyped. In our literature, there is continuing criticism of the ways in which excessive attention to theoretical constructs may blind analytic vision (Coen 2000; Eisold 2000; Josephs 2001; Levenson 1972; Richards and Richards 1995; Smith 2001; Spence 1982).

Some analytic perspectives appear to be more concerned than others by ways in which theory can narrow the range of clinical perception. Indeed, there is currently a strong countertheoretical trend toward pluralism and multiplicity, essentially an effort to deconstruct all theory, and to neutralize any theoretical hegemony.[1] This postmodern direction in psychoanalysis was initiated by the introduction of Sullivan's (1953, 1954) key concept of *participant-observation,* refined to what I call *observing-participation*[2] by analysts identified with the interpersonal school, particularly Thompson (1950), Wolstein (1954), and Levenson (1972). This approach to psychoanalysis was further elaborated into relational perspectives (e.g., Aron 1996; Gill 1982; Hoffman 1998; Mitchell 1988; Stern 1997) through epistemological concepts like constructivism and perspectivism, and integrated into the broader contemporary cultural ethos by psychologists and psychoanalysts interested in critical theory (Fairfield 2001; Gergen 2001).

The broad spectrum of interpersonal, relational, and postmodern thinking[3] reflects the development of theories that their proponents wish were not theories. They are theories in part

[1] See Fairfield (2001) for an excellent and balanced summary of this controversial issue.

[2] *Participant-observation* refers to the inherent subjectivity involved in any observation. As well, the act of observing, in and of itself, influences the data under observation. The concept of observing-participation places yet greater emphasis on the extent of analysts' unwitting participation with patients. Implicit in this perspective is the belief that analysts normally engage with patients in affectively tinged ways that are beyond their awareness, and, at best, analysts are able to observe this affective engagement only *post factum.*

[3] When referring to this now very broad grouping, I will usually use the term *interpersonal,* for this tradition most closely reflects my own theoretical background. The newer term, *relational,* serves as an umbrella for perspectives (including interpersonal) that in fact might differ from one another considerably around the question of the value and place of theory in clinical psychoanalysis.

born out of the desire to be atheoretical, and they live in contradiction—or, at best, in a dialectical tension—between theory and naive perception. Psychoanalytic theories basically tell us two things: what to look for with patients and what to do with them. General theory and clinical theory ought to be in synchrony, though often they are not. The nature of direct clinical work can be so deeply personal that the analyst's personality and idiosyncratic emotional reactions to each patient can readily dwarf theoretical predispositions, as well as premeditated guidelines for analytic interaction (Hirsch 1987, 1990, 1996, 1998).

Theories help keep analysts grounded in some bedrock or ritual (Hoffman 1998), while one hopes that the uniqueness of each analytic dyad is also engaged. Theoretical constructs draw a necessary ring of professional structure and boundary around what is otherwise usually a highly personal and affective relationship (Racker 1968). Nonetheless, "something more" than what our theories suggest (see Stern et al. 1998) tends to happen between the analytic participants. These *relational factors,* or unwitting (unconscious) participations, reflect the essence of what Sullivan (1953, 1954) originally meant by *participant-observation,* and what others (e.g., Hirsch 1987, 1996, 1998) have expanded to *observing-participation.* Theories always serve as guides to inquiry and to understanding, and as boundaries to potentially emotionally intense and confusing engagement between patient and analyst (Friedman 1988). However, in the trenches of analytic interaction, both general and clinical theory can also serve to restrict valuable spontaneity and idiosyncrasy (Hirsch 1987; Hoffman 1998), and to narrow analytic inquiry.

Those contemporary analysts who tend to view psychoanalysis as a science are normally more troubled by the perception of theory as essentially an expression of analysts' subjectivity, while those of us who view analysis as part of the social sciences or humanities are likely to embrace such contradiction as reflective of useful theoretical deconstruction. Analysts of all stripes prefer ideally to observe with a naive freshness and curiosity—the abandonment of memory or desire (Bion 1967), yet our theories

predispose us to prioritize what is seen.[4] In addition, some analysts whose work has defined this era (e.g., Greenberg and Mitchell 1983; Levenson 1972; Schafer 1983) have convincingly argued the case for multiplicity.[5] They maintain that there is no single correct, general theory, but rather that people can be well understood through the application of many different narratives or metaphors, and that a range of styles of therapeutic interaction can be mutative.

I suggest that the conception of a singular standard psychoanalytic technique no longer exists (see also Greenberg 1991; Hoffman 1998; Wolstein 1954, 1975), and that theory cannot tell us exactly what to do in the context of each unique patient–analyst dyad. Furthermore, and perhaps most significant, I see the mutative action of psychoanalysis more as a function of subtle, affective, interactional factors between analyst and patient, and of the analysis of that interaction (Abend 1999; Gabbard 1995; Gill 1982; Hirsch 1987; Levenson 1972; Renik 1993; Sandler 1976; Searles 1979), rather than as a function of any other clearly prescribed methodology.

Analysts representing disparate general and clinical theories help patients change. Theory is a context or grounding for how analysts understand patients and what is done with that understanding; it serves as an anchor for analyst and patient alike (Friedman 1988). Using theory as scaffolding and as a guiding light, analysts from varying perspectives and within traditional analytic boundaries stand to both expand patients' psyches, and to provide the opportunity to examine new, internalized experience. In the context of a theory of therapeutic action, successful analysts

[4] Some (e.g., Arlow 1987; Boesky 1988) argue that analysts can observe with a reasonable objectivity, and that both psychoanalytic theory and cultural myths may be used to provide *scientific* evidence for the accuracy of analytic observation.

[5] Multiplicity should not be confused with eclecticism. The latter refers to the idea that in working with patients, one may choose from a menu of viable conceptions and successfully apply this mixture to the work. Multiplicity implies that, although each analyst is guided by his or her own theory and tends to apply it with some consistency, no one theory can be scientifically demonstrated to be more effective than all the others.

are likely to relate to patients with a passionate commitment to understanding them (Billow 2000).

Though this understanding is likely structured by one or another theory, in the final analysis, the quality of the relationship and the examination of that relationship have much to do with whether or not other elements of personal awareness make much of a difference for patients. The conception of the analyst as an observing-participant (Hirsch 1987, 1996, 1998) effectively captures this dialectic between the bedrock of theory and the affective chaos of human engagement. The notion of observing-participation reflects an acknowledgment of the irreducible subjectivity (Renik 1993) of all analytic interaction, including both the conscious and unconscious imposition of preferred theories. Analysts' theories influence perceptions and interventions in ways that are commonly not recognized, or at best recognized only after the fact. The more analysts are aware of "theoretical countertransference," the less likely it is that theories will unduly influence patients—and, as well, constrict curiosity and flexibility.

The model of the analyst as participant-observer, evolving to observing-participant, has led to the relational turn, and heralded a shift from modernism to postmodernism in psychoanalysis. The notion of the analyst as inherently subjective—and, by definition, always "countertransferring"—has shifted focus from the study of the specimen patient *in vacuo* to the examination of the interactional field, including analysts' theories.

OBSERVING-PARTICIPATION AND ITS ROOTS IN THE INTERPERSONAL TRADITION

Born in the 1940s out of opposition to a psychoanalysis that conceived of itself as a natural science, and one that was perceived as too dominated by metapsychology,[6] interpersonal psychoanaly-

[6] Years later, in the middle 1970s, George Klein (1975) and others identified with the Freudian perspective made efforts to distinguish clinical theory (hermeneutics, or the investigation of meaning) from what they believed was excessive metapsychological (general theory) emphasis in clinical work.

sis has tended to prioritize praxis over complex theories of the mind. For analysts of this tradition, a focus on praxis has served as an antidote to the tendency to build overarching theoretical constructs. Nowhere is this ethos more evident than in Levenson's (1983) effort to capture the essence of interpersonal developmental theory through his minimalization summary: "People cause problems for people." His seemingly simple therapeutic aim is to wait for patients' internalized past experiences with others to emerge in the transference-countertransference playground, and to examine these recursive patterns in the analytic here and now. His striving for a theory of therapeutic action absent a strong general theory reflects the legacy of Sullivan (1953, 1954), as do his efforts to move analysis away from speculation about internal structures of the mind and toward dimensions of experience closer to the observational realm.

In fact, each interpersonal innovation to analytic practice may be seen as an effort to eliminate the power of theory, while simultaneously recognizing the impossibility of functioning as a theoretical blank screen. An almost phobic caution about presumptive general theory must be tempered by the recognition that each analyst has at least what Sandler (1983) called private theories, and that these inevitably exert both conscious and unconscious influence on praxis. Denial of one's own theory has the same disadvantages as denial of any other countertransference. For me, the axiom that "people cause problems for people," for better or for worse, translates into theoretical assumptions that focus my analytic inquiry and my interpretive predispositions.

Most essentially, I believe that personality or character is formed significantly by three primary relational phenomena: identifications with caretakers (Sullivan 1953), internalizations of familial self-other configurations (Bromberg 1999; Hirsch 1994), and conflicts surrounding efforts to separate from these key figures (Fromm 1941, 1964; Hirsch 1987; Searles 1979; Singer 1965). The essence of unconscious content, therefore, reflects these internalized relational configurations (Mitchell 1988) or

representations (Greenberg 1991), as well as the conflicts that surround them. Unconscious consists of conflicted internalized and elaborated real experience, and this template forms the basis of unconscious fantasy (Hirsch 1994). What constitutes unconscious process is normally less a function of repression than of experience that has never been formulated or put into language (Stern 1997). Much of what occurs developmentally (e.g., identifications) takes place without one's ever consciously knowing or articulating what is in process. Continuing to not know serves to maintain often comfortable attachments to familiar and familial experience. The ability to put into words the adhesive nature of one's early and unformulated experience—and its current manifestations, and conflicts that surround it—is key to the development of separation, individuation, and actualization of the potential for love and work.

Perhaps the most refined theoretical developmental conception shared by many interpersonalists, including myself, is the assumption of a universal conflict revolving around the wish to remain enmeshed within internalized familial configurations, on one hand, and the striving for the freedom and the loneliness of separation and individuation on the other (Fromm 1941, 1964). I view psychopathology as formed out of adaptations to and embeddedness in troubled familial integrations, as well as anxieties related to emergence from these (Fromm 1964; Hirsch 1987; Searles 1979; Singer 1965). These anxieties reflect efforts to save one's loved familial others from loss, and, as well, intense fears of losing their love (Hirsch 1994; Searles 1979; Singer 1965). Such compromised adaptations are carried forward into adult life (and into the transference), which unconsciously becomes structured to replicate the internalized past. Indeed, personal problems lie not in the troubles of the past per se, but in the repetition of that past in contemporary life.

My rather brief review of theories of development, unconscious process and conflict, and psychopathology is reflective of my attachment to the interpersonal psychoanalytic tradition of minimizing general theory in favor of an emphasis on praxis.

It is worth noting that contemporary attachment theorists and researchers (e.g., Beebe and Lachmann 1988; Fonagy 1999; Seligman 2001; Stern et al. 1998), more at ease with the adoption of universal theoretical conceptions, have established a developmental schema very much in harmony with the far more loosely and generally outlined interpersonal conceptions. Large gaps in the details of understanding human development—those left by theory- and techno-phobic interpersonalists like me—are becoming increasingly elaborated by parent--child observation researchers. Though this research convincingly supports views of the inherently relational nature of internal experience, one hopes that this does not turn the clock back to a time in psychoanalysis when every patient appeared to develop according to the same fixed schemata.

As already noted, the overriding contribution of the interpersonal tradition lies in the expansion of the blank-screen, one-person psychology model of the analytic relationship to a two-person, intersubjective model of participant-observation, extended to observing-participation.[7] Theorizing about the insides of patients' minds thus became secondary to learning about patients primarily in the context of an inquiry into both extratransference data and the mutually constructed analytic interaction. Observation of patients' reports about their interactions with others, in tandem with observation of transference behavior, has made analytic inquiry less speculative, and therefore somewhat less prone to theoretically biased understanding. Sullivan attempted to move psychoanalysis away from experience-distant speculation about structures of the mind that were not visible to the observer, and toward dimensions of experience closer to the observational realm.

[7] It should not be overlooked that the relational turn in psychoanalysis began with Sullivan's (1953) shift in emphasis from a biologically or instinctually dominated theory of the mind to one emphasizing exclusively the study of interpersonal relationships as building blocks of the mind (Greenberg and Mitchell 1983). I have not emphasized the importance of this redirection because it has already been the subject of much discussion in the analytic literature of recent years.

Though Sullivan's emphasis in his detailed inquiries into patients' lives was largely on historical and other extratransference events, contemporary analysts have extended these inquiries to focus on the analysis of transference (Gabbard 1995; Gill 1983; Hirsch 1987, 1996, 1998; Levenson 1972, 1983). The following four dimensions of witting clinical interaction, all of which bear relation to my own general theory, dominate my work: detailed inquiry, subjective observations, examination of the analytic relationship, and interpretation. Except for interpretation, each of these modes of interaction is designed to minimize the intrusion of presumptive theory.

Because the building blocks of the mind and of unconscious fantasy are viewed as based on internalized and conflicted real experience with others, one analytic aim is to carefully examine the patient's life history and current life with others. The detailed examination of early relational experience helps make sense of what might otherwise remain mystifying developmental phenomena. Sullivan believed that asking good questions was a distinct analytic skill, and what qualified as "good" often meant the ability to see the gaps and inconsistencies in patients' descriptions of their life histories. Precise memory is unrecoverable or unknowable, but the ability to put words to pivotal relational experience that has never been formulated as such stands to provide patients with a stronger sense of grounding and personal agency.

Inquiry has the advantage of helping patients to fill in their own gaps in awareness. It also reflects the analyst's interest—a wish to know the patient, which, if authentic, is inherently empathic. For me, the analyst's questions take priority over the analyst's answers, the latter often expressed in the form of theoretically biased interpretations. The description of experience carries greater weight than the explanation of experience, and addressing the question of "what" takes priority over "why." The activity of inquiry in and of itself may involve a more vocal analyst than is seen in traditional models, though the degree of activity is usually more a function of the analyst's individuality than of his or her theory of therapy (Gill 1983). However, de-

tailed inquiry should not be confused with fact finding. Though Sullivan believed that he uncovered "real" experience, contemporary analysts like myself view all data as perspectival and as influenced by the analyst's participation. The "what" that we find in our inquiry is never more than an approximation or a co-construction of what really happened, and this acknowledgment reflects the essential attitude of an observing-participant model.

The potential for an analyst to be somewhat more verbally active than tradition originally dictated is also evident in my proclivity for sharing my observations about my patients with them. These subjective observations are not to be confused with deliberate self-disclosure, though some analysts may equate these two types of interventions. While the observations I tend to make are by definition informed by countertransference, I do not speak of my feelings as such; I normally attempt to translate my feelings into observations about something transpiring in the immediate interaction between my patient and me. This often refers to attitudinal, tonal, or nonverbal aspects of our interaction (see Jacobs 1991). These frequently subtle and commonly unattended features may have considerable impact on the way a patient structures his or her world with others. This alternative type of insight stands to help patients view themselves as active (albeit unconscious) agents, repeating early conflicts in the context of the transference-countertransference matrix.

One way to think about this form of analytic interaction is that it provides a nongenetic form of insight from the perspective of the other. This differs from the more empathically oriented, detailed inquiry, the effort to understand the patient through his or her own expressed experience. The interpersonal tradition is somewhat distinct from other points of view in its emphasis on the role of the analyst as a subjective other—an unwitting participant who may also wittingly provide subjective observations (see Ehrenberg 1992; Fromm 1964; Wolstein 1975). Some other psychoanalytic models have situated the analyst exclusively as either an objective observer or an empathic one. The analyst as allegedly objective observer is inevitably one

laced with a strong theory. The analyst as empathic observer may all too readily assume that his or her feelings and the patient's are one and the same—the phenomenon that has sarcastically been referred to as *immaculate perception.* By contrast, the analyst as subjective observer of immediate experience reflects an affinity for existential influences in psychoanalysis (e.g., Farber 1966), and can be seen as making yet another attempt to illuminate the experiential moment (Ehrenberg 1992) and to control the imposition of theory into analytic interaction.

The analysis of the analytic relationship is probably as close as it is possible to get to what I would describe as standard technique, though this predilection has gone well beyond the interpersonal tradition (e.g., Gabbard 1995; Gill 1983; Renik 1998; Sandler 1976). As long as the analyst is reasonably restrained and recessive, the analytic relationship inevitably begins to resemble the structure of the patient's key internalized relational configurations. Individual lives are remarkably recursive (Levenson 1983), and it does not take long for the analytic dyad to take the form of the patient's fundamental relational patterns. This interaction is never intended, but I find that the nature of the material discussed by the patient comes to be mirrored in the interaction between the patient and me (Levenson 1972).[8] The analytic playground thus becomes the setting for the living out of old, internalized configurations, and the analysis of this experience in and of itself is reflective of an evolution to something new and potentially broadening.

The analytic relationship serves as the ideal vehicle to study the way in which patients shape their current world to conform to the past. The observing-participant analyst enters this world unwittingly, and at some point sees firsthand the mutual repeti-

[8] Greenberg's (1991) discussion of participant-observation is relevant here. He argued that analysts cannot *not* participate (at least unwittingly), and that participant-observation is not a technique or a *prescription,* but rather a *description* of what inevitably occurs in any dyadic engagement. According to Greenberg, the object of psychoanalysis—the study of the patient's mind—can never exist independently of the observer who is interacting in the study.

tion of the past in vivo. The conception of transference as enactment is further specified as enactment in the transference-countertransference matrix—the interpersonalization of the concept of transference (Aron 1996; Gill 1982, 1983; Hirsch 1996, 1998; Hoffman 1998; Jacobs 1991; Renik 1993; Sandler 1976; Stern 1997). Here, too, one can see the effort to minimize presumptive theory by prioritizing the examination of immediate experience—the emerging unconscious interaction between patient and analyst. The elucidation and verbal examination of a mutual enactment that reflects a key internal conflict may serve to break the interlock of old, repetitive patterns. Putting previously unformulated experience into words (Stern 1997), in and of itself, may constitute a new and salubrious experience.[9]

Interpretation is always part of psychoanalysis, and by definition cannot be free of theoretical influence. My fundamental theoretical assumption is that the mind develops out of dyadic interaction, and that this internalized template operates unconsciously to structure contemporary life to conform to the past. What is usually most deeply unconscious, short of discrete trauma, is the conflict between maintaining the love of significant others by endlessly repeating the past, and actualizing oneself at the mutual cost of separation and aloneness (Fromm 1964). I look for this conflict in my detailed inquiry into the patient's past experience, and I point out its manifestations in the way the patient interacts with me.

[9] From my perspective, new experience does not emerge by premeditated design, but as a byproduct of the analysis of the analytic interaction. Other psychoanalytic traditions attempt to build new experience into a consciously designed technical procedure. For example, "holding," "containing," and "empathic immersion" are premeditated modes of engagement that are geared toward providing patients with experiences that are essentially better than those that have been internalized. These latter experiences are often "provided" by analysts without their analyzing the interaction itself or its consequences. The new experience of which I speak is often lumped together with these other approaches by some Freudian analysts who may valorize an interpretation-only approach to praxis. In fact, the way of functioning that I outline here emphasizes continual examination of the analytic interaction, and the new experience that evolves in this context is, therefore, understood quite differently than that described by many object relational and self psychological theorists.

Since I believe that unconscious process is most clearly seen in dyadic interaction, I expect unwittingly to enact with my patient some approximate repetitions of key internalized configurations. These mutually unwitting interactions are our clearest approximations of our patients' internal lives, and this is usually seen most dramatically after it has been enacted in the analytic playground. Mutual enactments occur spontaneously, and emerge out of the normal and mundane modes of analytic action: listening, inquiry, observation, and interpretation. If the analyst becomes too vigilant in trying to recognize transference-countertransference enactments, it is likely that their development will be thwarted or resisted. Once enactments emerge into awareness, the significance of these recursive patterns in the patient's life history usually becomes clearer. Attention to the analytic here and now leads to clarification of the past.

Though interpretive explanations can be the easiest and most academic part of psychoanalytic praxis, intellectualization may become problematic if interpretive insight is not held to that which emerges from the immediacy of the transference-countertransference matrix. Even under the best of conditions, insight via interpretation is inevitably enmeshed with theoretical constructs; the analyst as observing-participant can never observe separately from his or her participation as a person and as a theorist.

CLINICAL ILLUSTRATIONS

The two clinical summaries I present are unremarkable in and of themselves, but to a reasonable degree, they reflect both the general and clinical theories I have tried to outline. It is quite possible that my thinking and my approach, as illustrated by these examples, are not especially distinct from those of analysts representing other theoretical traditions. Emphasized in these vignettes are the role of the analyst as subjective observer and as an unwitting participant in actualizing patients' transferences. The use of detailed inquiry, a staple for many interpersonalists, is not so central an aspect of my own analytic participation, and

is not prominently illustrated here. I provide only a few examples of interpretations in these vignettes, though the data is pregnant with interpretive possibilities. The reader can readily see the genetic links in the interactional data. It is but a small step for either my patient or me to draw parallels between the recursive patterns in the transference-countertransference matrix and those that lie in the patient's internalized life history.

Scott

Scott, in his middle twenties, presents a symptomatic history of poorly controlled anger, initially taking the form of adolescent brawling and more recently expressed in extreme impatience, intolerance, and argumentativeness. His physically violent and bullying behavior culminated in his suspension from high school for part of his senior year, despite his being near the top of his class in grade point average. Postcollege (where he had excelled in varsity wrestling, and largely reformed his physically bullying ways), Scott accepted training positions at first one, and then a second, top-tier Wall Street investment banking firm. In both instances, his technical performance was exemplary, yet he was fired for his surly and belligerent manner. He began analysis while unemployed, wishing to prevent further self-destructive aggression.

An only child, Scott is Central American by birth, abandoned in the streets by his mother, and adopted from an orphanage at about one year of age by upper-class, white, Protestant, native-Californian parents. He is short, squat, and brown-skinned, with distinct Native Indian features. He was raised with privilege by parents whom he described as devoted and loving, though noted that his father could be explosive, argumentative, and held fierce grudges. On the surface, Scott identifies with the noblesse-oblige aspects of his family and cultural background. He has excellent and expensive tastes and interests. He shows virtually no interest in his personal or cultural heritage, and has never traveled to Central America nor researched his biological begin-

nings. He is rarely conscious of his racial properties, except when rebuffed by the tall, fair, and blonde women he uniformly desires. On the other hand, Scott's dreams are replete with imagery suggesting both a strong sense of difference and an inclination toward hypervigilance based on danger. In his initial reported dream, he spoke of being in a room where it was his task to kill scorpions that continually emerged from cracks in the walls of his costly Manhattan apartment.

My earliest contacts with Scott left me feeling chilled (as in ignored), intimidated, and angry. It took numerous phone messages to finally speak and to make an initial appointment. When we eventually met, I found Scott cold, clipped, terse, and impatient with my initial questioning. He was businesslike, neither reflective nor curious, rarely elaborating on answers to my queries, reporting dreams, or initiating dialogue. He usually looked like he could not wait to leave, and appeared bored and restless. After asking him what it was like to be with me and getting a noncommittal answer, I observed that it seemed to me that he was generally angered and/or bored by my presence, barely tolerant of my existence. Scott replied that he was neither, but that this experience was simply uncomfortable and unfamiliar. When I pressed, referring to my evidence (e.g., terseness, restlessness, disengagement, and annoyed and bored facial expressions), he became overtly angry, declaring that he had already answered what I was asking, and demanding to know why I was trying to provoke him. I backed off, realizing only much later that this reflected the first of my many abandonments of him.

After only two months of analysis, Scott found a good new job, and appeared to be controlling his anger and his brusqueness with colleagues. His sense of urgency about his analysis diminished. The time in our sessions moved very slowly, and there was abundant silence. I felt generally inhibited, though too tense to be bored. After a couple of months of this trying experience, Scott failed to appear for a session, without calling. I was convinced (and somewhat relieved) that he had quit. But

when he arrived for his next session, he said that he had had an emergency business meeting. When I asked why he had not phoned, he stated that he knew he was to see me again in two days anyhow. The next time he canceled, he called in advance and asked for an alternative time. I returned his message, asking him to confirm the time I offered, and his one-day-late return message was barely decipherable: "Hi, that's okay." He did not leave his name with the message or engage in any other social amenity. When I questioned Scott about having taken so long to call back, and about not having left his name, he was dismissive and exclaimed that I was wasting his time with such petty interests; he had most likely simply been busy at work.

At about this time, Scott began to yawn increasingly frequently during sessions, and these yawns were becoming noisier, with his hand failing to cover his mouth. By this time, my own feelings ranged from invisibility, to identification with the high school kids whom this thick wrestler had beaten to a pulp, to the angry and retaliatory feeling that I was with someone who was uncivilized—someone whom I wished would disappear from my life. I asked him if he was aware of his increasingly loud and uncovered yawns, and he responded that he must be suffering from the effects of long work hours and early-morning sessions. At this juncture, I told Scott—probably with some edge to my voice—that his manner on the telephone, his yawning, and his general absence of social decorum were striking. I suggested that, given his social background, this must have considerable psychic significance. I added that I thought he was trying to get me to boot him out of treatment.

To my surprise at the time, these observations were not met with a slammed door. I became more free in pointing out both subtle and gross interactional nuances, especially his interactions with me that tested my tolerance. Though there was still considerable combativeness on his part, very gradually my observations led to linkages with and articulation of such issues as: the patient's uninhibited violence and argumentativeness as related to feelings of difference, inadequacy, vulnerabil-

ity, and tenuousness; feelings that his mother did not find him physically attractive; fierce verbal fights with his father, during which both cursed unabashedly, ignoring the cultural standard of relative parent–child restraint; and Scott's early identifications with what he began to construct as the crude peasant status of his biological parents in his impoverished and decimated country of origin.

I am aware that my perception of Scott as primitive and unsocialized reflects a mutual enactment of his and his parents' struggle around the complicated ambivalences of adoption in general and this mixed-race adoption in particular. My strong wish to be rid of the patient and my early retreat from uncomfortable confrontations reflect a repetition of his original abandonment, his adoptive parents' conflicts about loving him, and, as well, the ultimately self-destructive situations he initiated with women, employers, and others. These themes are still observed and addressed as they continue to be played out in the transference-countertransference matrix.

Katharine

Katharine, who prefers to be called Kate after her primary icon, Katharine Hepburn, is unmarried, in her early forties, and strikingly attractive. She is on medical leave from work because of a variety of orthopedic problems and related chronic pain. To this point, she has had a successful career as a top-level administrator in a prestigious investment bank, after having done similar work for some time in a prominent law firm. She initiated analysis because she felt depressed by how limited and how inhibited her physical problems have rendered her. She is, like her namesake, a woman of fierce independence and vitality. She meets me with a warm and infectiously engaging smile, and with mannerisms that always convey a strong interest in and concern for the well-being of the other. She tells me about her social and cultural activities, and in so doing, somehow seems to intuit my own interests. Indeed, I am often tempted

to engage with her in dialogue about these shared interests. I believe that she would gladly spend her sessions pleasantly listening to me. Indeed, my patient appears to visit me more to enhance my life than to take away anything for herself.

Kate's manner of maintaining control and disconnecting from her anger and dependence has served her well in her career as a super administrator, as she has ultimately helped her lawyers and young bankers to make far greater fortunes than she strives for in her own right. She speaks compassionately about the serious troubles both of her dysfunctional family and of her depressed, single women friends. As the oldest and brightest of a middle-class, Catholic family of five children, Kate has always subordinated her life to those of family members. She turned down scholarships to outstanding universities in order to stay at home and repair her parents' marriage. The marriage began to unravel anyway, precipitated by her father's sexual infidelity, at the time she was finally deciding to leave for school. This breach broke both her mother's and her own heart, and her idealization of her father crashed.

Kate later worked part-time while attending a mediocre college. In her spare time, she tried to heal her mother, to patch up her parents' marriage, and to tend to the variety of moderate to severe drug and alcohol problems of her younger siblings. Two of her siblings remain very seriously dysfunctional addicts, and more of her time and energy is devoted to helping and rescuing them than in rehabilitating her own orthopedic pain, in resuming her career, or in pursuing available men. She rarely allows herself to experience her anger about the demands of her family and the resultant cost to her. To the contrary, she tries to enlist me in finding appropriate mental health facilities for her recalcitrant family members.

For a woman as bright, good-looking, interesting, and charming as Kate, her love life has been relatively spare. She has had only a handful of lovers, two reasonably long-term. She has enjoyed sex only moderately and has rarely experienced orgasm. Kate has enormous trouble surrendering to dependence, and

has a history of essentially giving away men with whom she could lose herself in love and in desire. She becomes frightened of men toward whom she becomes "too attracted." I am relatively close to her father's age, and she guiltily reports neither sexual desire nor sexual dreams related to me. Her conscious involvement with me *(avuncular* is the word she uses to characterize me) is considerable, but as with most others in her life, it seems based on her concern for my mental and physical health and my general well-being.

I have much concern that my patient's orthopedic pain is largely psychosomatic—the only way to curb her Calvinistic work ethic and caretaking energies and to receive hands-on help herself. I raise this question repeatedly as she walks into my office, orthopedically twisted or bent, takes a pillow to place behind her lower back, and smiles glowingly while asking about me. I have told her many times that I believe there must be a psychosomatic component to her pain, interpreting this as her only legitimate way to regress and to be cared for by me and others. She appeases me in a condescending way by telling me that I must be correct, though none of her physicians have concurred with this hypothesis. She does report that they seem frustrated in their inability to help her, though she acknowledges no more anger or discontent with their failed efforts than with my own.

When Kate enters my office, smiling, with her body somewhat contorted, I am likely to ask her why she seems so happy, and so concerned about me, when there is so much pain and misery in her own life, so much to be angry and bitter about. She will usually tell me that she is glad to see me, independent of her pain and other problems; she says she is fond of me, and is grateful that I try so hard to be helpful. I suggest to her that she appears less interested in my taking care of her than in making this a pleasant engagement for me—that I am no more potent in my impact on her than are other men in her life. She argues that I am wrong, that it is very hard for her to do this kind of therapy—to talk openly about humiliating matters like family pathology, sexuality, and her body. I acknowledge

that this is a departure for her, though her pleasant demeanor belies both tears and rage, and in fact constitutes an effort to keep me at bay, to control my impact on her life. She sometimes assents verbally, but I am unclear as to whether she is really with me here.

When Kate used to enter my office and bend to fetch a pillow to place behind her, I would ask why—since I was closer and had no back problems—she did not ask me to hand the pillow to her. She would belittle this question as too silly to address; it was barely an exertion on her part. I might tell her that I thought she hated being taken care of by me, preferring instead to be in control of me. Kate's likely response was an effort at encouraging me, telling me that she had opened up to me as with no one ever before, and that I was indeed taking excellent care of her. She can be quite disarming.

Recently, after gathering up the pillow that she uses at each session, I told Kate that I had been wondering how she would respond if I simply handed her the pillow as she walked in. She was excessively exuberant in her gratitude at such a generous thought, exclaiming how unnecessary it was for me to think of such things, given all the patients I must have on my mind. I pressed, and she appeared uneasy at the idea of receiving something. I told her that I thought she was afraid of being "too attracted" to me, asking her if she recognized how hard she was struggling to neutralize my significance in her life. In a still more recent hour, when Kate's perky demeanor once again seemed especially forced, I suggested that her upbeat pleasantness might represent an effort to keep me superficially interested, yet at considerable arm's length.

This theme continues as a major agenda in Kate's analysis, inevitably surfacing through my process observations about (often nonverbal) interactional phenomena. Kate has yet to initiate verbally that she fears regressing with me, mistrusts my fidelity to her, is angry or disappointed that I do not help her sufficiently, or is more comfortable being in control of me than the obverse. Remarkably, despite my relative impotence, dur-

ing any given moment in a session, I still find myself feeling more enhanced by her presence than she seems to be aided by mine.

CONCLUDING SUMMARY

Despite every effort to minimize the influence of theory on the uniqueness of each analytic dyad, my basic theories of development, unconscious motivation, and psychopathology are imprinted on my clinical work. Observing-participation stresses praxis, particularly those witting participations that are designed to observe the patient with a mind as free from theory as possible (detailed inquiry, subjective observations based on immediate interactional experience, explicit attention to the analytic interaction, and the examination of mutual enactments *post factum).* Though my clinical interaction is highlighted by these features, my general theoretical predisposition is nonetheless evident.

In a nutshell, I see both of the patients presented above as repeating key aspects of internalized experience in their extratransference lives, and with me in the analytic interaction. Each struggles with a core conflict between adhesive embeddedness in early attachments and a striving for separation and new experience. Among Scott's attachments to his key internalized relations, for example, are his primitive and provocative ways. A significant unconscious fantasy relates to the real experience of having been orphaned. Scott both anticipates this and repeatedly provokes these reabandonments, while simultaneously hoping that something better will happen. This core conflict is enacted in the analytic dyad, in which I abandon Scott in many subtle ways as I try to resist the wish to get rid of him entirely.

Kate's mission in life, long internalized, is to sacrifice her own potential in order to preserve her parents' marriage, and the special place for her with her father. She brings this sacrificial, missionary zeal into her life with others, and into the trans-

ference, her physical symptoms serving as a point of entry to allow dependence. Kate's wish to surrender to a narcissistic dependence is palpable yet largely unconscious, and she is extraordinarily controlling. She repeats her characteristic way of being, as all patients do, in the transference. So, despite my feeling quite impotent in terms of making an impact on her, she can be so beautiful, vivacious, charming, and intelligent that I nevertheless often feel that she gives me more than I give her.

Analysts representing the interpersonal tradition within the broader relational perspective are highly suspicious of fixed theoretical conceptualizations and all types of positivistic assertion of knowledge and authority (Mitchell 1997; Renik 1998). Though many contemporary analysts wish that they could be free of theory, most have come to a position of compromise, viewing theory as an essential part of inherent subjectivity.

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THE *JOUISSANCE* OF THE OTHER AND THE PROHIBITION OF INCEST: A LACANIAN PERSPECTIVE

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The authors describe how Lacan diverged from classical Freudian concepts to arrive at an alternative model of psychoanalysis. In a discussion that also addresses the concept of the mirror stage and Lacan's use of language, the authors show how the Lacanian concepts of jouissance *and the prohibition of incest contribute to this model, which can be successfully applied to the psychoanalytic treatment of more seriously disturbed patients. A clinical vignette is presented to illustrate the latter point.*

INTRODUCTION

Jacques Lacan's contribution to psychoanalysis is usually perceived in the United States as having associated Freud's discovery of the unconscious with the field of structural linguistics. The distinction between the signifier and the signified, along with aphorisms such as "the unconscious is the discourse of the Other" (Lacan 1977, pp. 55-56), often gives the impression that Lacan has reduced the workings of psychic life to linguistic laws that bear little connection to the actual experience of the individual.

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Lacan's return to Freud, however, did not merely formalize Freud's work; it actually attempted, like many other psychoanalytic schools, to move beyond Freud. But Lacan's strategy differed from other approaches. Instead of criticizing Freud's concepts, Lacan preferred to find in Freud's own writings the necessary elements that could, as it were, set Freud against himself.

Lacan's main concern was to give coherence to the most radical and controversial of Freud's ideas, such as the concept of castration, the death drive, and the riddle of femininity. He was also very interested in discovering why Freud was unable to bring the psychoanalytic treatment to a close. Lacan (1977) approached these difficult questions through two concepts that were not specifically elaborated by Freud himself: the desire of the Other and the *jouissance* of the Other.[1]

THEORETICAL DISCUSSION

Let us note at the outset that the term *jouissance* cannot be easily translated to the English word *enjoyment. Jouissance* is a legal term —in Latin, *usufructus*—referring to the right to enjoy the use of a thing, as opposed to owning it. The *jouissance* of the Other, therefore, refers to the subject's experience of being for the Other an object of enjoyment, of use or abuse, in contrast to being the object of the Other's desire. The experience of being perceived as an object of desire implies that the individual can figure out what it is about him- or herself that attracts the Other. The desire of the Other in that sense offers the subject clues to what it would take to behave or to be what the Other wants. In contrast, the experience of being the object of the Other's *jouissance* conveys a sense of frightening mystery: What is going to become of me?

[1] The *Other* with a capital *O* refers primarily to the image the child has of its caretakers before the child realizes that such an Other is barred, i.e., that the Other does not have the power to determine the fate of the subject. The Other of the child, like all human subjects, is above all a speaking being; that is, he or she is subject to the rules and regulations that make society possible.

What does the Other want from me?—and so on. This is a situation in which the subject is unaware of certain aspects of the Other, who appears as enigmatic, as able to threaten the very core of the subject's being. The goal of psychoanalysis, therefore, consists of demystifying the Other in its all-powerful and threatening incarnation.

Through his concepts of *jouissance* and desire, Lacan reworked Freud's (1905) stages of development and his drive theory into a system dominated by the idea that the Other is instrumental in the production of subjectivity. In other words, the realm of fantasy is not the effect of the maxim "anatomy is destiny"; rather, the realm of fantasy is determined by the way the child situates him- or herself in relation to the *jouissance* and the desire of the Other.

The Mirror Stage

How do the desire of the Other and the *jouissance* of the Other come into being? How are they the effects of psychic development? The birth of the subject's desire can be traced back to what Lacan (1977) called the experience of the mirror stage. The mirror stage can be viewed as a structural moment in the psychic development of the child when he or she encounters in the mother's gaze the image that will shape the child's ego ideal. In other words, the mirror stage inaugurates for the child the moment of experiencing that he or she is the object of the mother's desire and love. Yet the experience of the child as the apple of the mother's eye, as the exclusive object of the mother's desire, of course presupposes that the mother is a desiring being—in other words, that she wants something that she does not have. The experience of being the object of the Other's desire, then, implies that the subject registers that the Other could also fail to occupy that position. In Lacanian terms, this translates as the child's need to come to grips with the fact that the mother is lacking, and that something or someone is able to fill that lack. This is why Lacan noted that castration is the ability to recognize the basic lack in the (m)Other.

The mirror stage, in that sense, differs from Winnicott's (1956) idea of mirroring. The mirror stage includes three agents, not two. The child views him- or herself as the object of the mother's desire, and through her loving gaze is able to identify with the perception of him- or herself imputed to the mother. Yet this recognition depends on a mother who conveys to the child the sense that her desire exceeds the pleasure that she derives from the sight of the child. In other words, the child must *work* to capture the mother's attention. Such a seductive strategy requires the child to figure out, to a certain extent, what it is that the mother lacks. What is the nature of her desire? Where does she go to get what she wants?

This does not mean, of course, that the mother lacks a penis, but rather, as Freud noted in his last essay on femininity, that she lacks the phallus, and that she lacks that which could bring her fulfillment. Lacan read Freud differently than did those of other schools, some of which continue to insist that Freud equated penis and phallus. For Lacan, the phallus, at least at the level of the mirror stage, represents for the child the signifier of the mother's desire, meaning the object of her desire. It is important to reiterate that castration for Lacan referred to the child's ability to recognize that there is a space between him or her and the mother. In order to try to occupy that space—to become the phallus of the mother—the child must recognize that the mother has a desire, and therefore, that she is not self-sufficient. However, if the mother's desire cannot frame her child as a separate being whom she can admire, love, and desire, the child will instead encounter the mother's *jouissance*—that is, a realm of enjoyment that is not symbolized, something akin to Klein's (1992) definition of the maternal superego or Kohut's (1971) selfobject. The child's exposure to the mother's *jouissance* is a necessary part of oedipal dynamics.

It is extremely important to realize that *jouissance* belongs to a different register than that of desire. As long as the child views him- or herself in the mother's gaze as the exclusive object of her desire, the child is spared the experience of her *jouissance*.

It is only when the child comes to realize that the mother wants something that the child does not have that the threat of her *jouissance* will become real, and the child will be forced to change position. It is at that juncture that the child's status as an object of desire will be jeopardized, and the sense of unity that he or she has derived from the mother's gaze will give way to a fear of being devoured by the Other's incomprehensible demand.

Such fundamental anguish forces the child to find a solution to this frightening situation. If the child is not the exclusive object of the mother's desire, the child may risk becoming the object of the m(Other)'s *jouissance*. The child will be led to wonder, What does she want from me? What can I do or be to satisfy her desire? Is there something or someone else that can answer her enigmatic demand? In other words, the anxiety created in the child by the *jouissance* of the mother triggers the necessity to find a remedy for what feels like a threat to the child's existence. The solution to this frightening riddle is precisely where Lacan situated castration, that is, at the moment when the child is able to give a *translation* of the mother's incomprehensible demand: *There is something or someone other than me that she wants, and so I must relinquish the position of being the exclusive object of her desire.*

The Prohibition of Incest

It is at this crossroads between the *jouissance* of the Other and the desire of the Other that Lacan located the introduction of the prohibition of incest. This prohibition was perceived by Lacan as the child's ability to identify with the clues, the signposts —signifiers—of the mother's desire for somebody or something else. This can lead the child to a safer harbor, usually provided by the desire and interests of the father. We can see here how Lacan rejoined Freud's oedipal dynamics via another route: the child is not forced to leave the mother and her *jouissance;* rather, he or she is led toward the paternal realm, thanks to the

mother's directives. Lacan added to the Freudian apparatus a dimension that creates a bridge between Freud and Klein. The signifiers of the mother's desire save the child from her *jouissance*. In that sense, the real person of the father can function as a limit to the mother's *jouissance* only under the condition that he is desired by his wife/lover. Again, the signifiers of the mother's desire therefore provide a limit to the mother's *jouissance* in the sense that they propel the child toward new poles of identification, usually provided by the father, through which the ego ideal will be constituted.

If, however, the mother's desire encounters certain vicissitudes resulting in the mirror stage's obscurity by her *jouissance*, the child will need to find alternative mechanisms to fend off a maternal demand that resists any form of symbolization. Therefore, if the child encounters in the mother's gaze an excess of *jouissance*, she or he will be reluctant to leave the maternal realm. The image that is being sent back will not sufficiently reflect the sense that the child stands as a love object, that is, as an entity separate from the mother. The mother's desire for the father, for example, may not be sufficient to separate the mother–child symbiosis, so that an excess of maternal *jouissance* will return as the *jouissance* of the Other through the injunction of the superego—that is, as a punitive and arbitrary force of which the child cannot make sense. (This is why Lacan emphasized the distinction between the punitive dimension of the superego and the protective aspects of the ego ideal.) For example, the child may experience an excess of anxiety for failing to be what will adequately please the mother. The child is not good enough not because he or she is not as good as the father—the realm of the mother's desire—but because nothing seems to please her, or because she is too depressed to enjoy any form of pleasure.

We are speaking here, of course, of neurosis only. In psychosis, the *jouissance* of the Other completely prevents the law of the prohibition of incest from becoming operative. Lacan understood psychosis as a result of the child's inability to escape or to set a limit to the mother's *jouissance*.

The Lacanian Use of Language

It is at this point that Lacan's usage of structural linguistics becomes meaningful. At the risk of being reductive, let us simply say that Lacan reversed our intuitive assumption about the relation between the *word* and the *thing*. It is not the thing that waits for a word to represent it; rather, it is the word that creates the thing. Language in some fashion precedes the world it represents. When Lacan (1998) wrote that "the unconscious is structured like a language" (p. 48), he meant, among other things, that the unconscious is not the repository of the drives, nor the storage room for "thing-representations"; it does not have a fixed content.

In that sense, Lacan transformed the Freudian understanding of primary repression. What is repressed is not the forbidden oedipal yearning, but rather the signifiers that mark the psychic separation from the maternal realm. These signifiers in turn do not have a fixed meaning; they slide according to the rules of metonymy and metaphor that Lacan compares to the processes at work in dreams, namely, condensation and displacement. The unconscious, therefore, evokes through a process of chain reaction the very experiences that allow the subject to be cut off from the *jouissance* of the Other. For Lacan, this cut is castration. The subject, then, is born into the world of signifiers at the moment when the *jouissance* of the Other becomes translated into the desire of the Other. As Lacan (1977) wrote, "Castration means that *jouissance* must be refused, so that it can be reached on the inverted ladder . . . of the Law of desire" (p. 324). Here we begin to see Lacan's castration and Freud's superego parting company. This transformation from *jouissance* to desire does not involve for Lacan, as it did for Freud, a paternal injunction that forces the incestuous or oedipal fantasy underground; it is rather that the oedipal fantasy is created as an aftereffect of symbolic castration.

To put it another way, the unconscious signifiers that unwittingly inform our existence constitute the proof that we are de-

siring subjects, that we have been saved from the grip of maternal *jouissance*. Yet, because these signifiers evoke separation rather than fusion, our psychic economy—which remains dependent on the rewards of the mirror stage (that is, of being the exclusive object of the Other's desire)—clings to a fantasy that necessarily ignores the enabling function of castration.

This is where Lacan brought an interesting twist to Freudian theory. The fantasy of incest is not the cause of primary repression. It is rather that the fantasy of incest is produced after the formation of the unconscious. The signifiers of the desire of the Other that constitute the chain reaction at work in the unconscious represent the desire of the mother for something or someone other than the child, and ultimately, it is with the help of these signifiers that the child will fabricate a fantasy of what could bring fulfillment to the mother. Such a fantasy thus emanates from the standpoint of the desire of the Other. In turn, we expect that if we bring fulfillment to the Other, we can (re)capture the sense that we are the exclusive and unconditional object of the Other's desire.

It is in this sense that the incestuous fantasy becomes a secondary formation, and in order for us to have this fantasy, castration must necessarily have already occurred. The oedipal fantasy requires that we have access to the signifiers of the desire of the Other, in order to foment a fantasmatic strategy that makes us the ideal ego for the Other. Because the *jouissance* of the Other is necessarily out of reach, the distance that separates us from it enables us to invent a fantasy that permanently fuels our desire. Yet if we could access this *jouissance,* our very existence as subject would be jeopardized. It is as if we are thinking, at the level of the unconscious, not with our own words but with the words of the Other. This is why Lacan (1977) noted that the unconscious is "the discourse of the Other" (p. 55), and that human desire is the desire of the Other (pp. 311-313).

The way in which Lacan conceptualized the subject's wish to recapture the incestuous fantasy, whose loss has enabled desire to be born, thus gave Freud's notions of castration anxiety

and penis envy a whole new meaning. Castration, for Lacan, is not a fear that is carried over by the superego after the dissolution of the oedipal complex; instead, castration assures the birth of the subject, whose desire is constituted by the signifiers of the desire of the Other. Thus, castration is not a threat that awaits the subject. It has, in fact, already occurred, and castration anxiety and penis envy need no longer be perceived as the psychological strata that led Freud to reach "bedrock."

The injunction of the superego and the fantasy that it condemns are both psychic inventions that attempt to deny the threat posed to the subject by the *jouissance* of the Other. Since the oedipal fantasy is experienced as a transgression, the need to keep it alive exposes the subject to a threat emanating from the superego. Castration anxiety and penis envy, therefore, are neurotic constructions that attempt to keep at arm's length a demand for a pound of flesh that the subject refuses to deliver. In order to keep the fantasy alive, the subject evokes the superego, under the guise of an imaginary, frightening father, so that fear of transgression can offer the guarantee of a beyond where dreams can be fulfilled.

The Lacanian Psychoanalytic Model

What Lacan offered psychoanalysis, then, is an understanding of how the subject has been misled in believing that the object of his or her desire lies in the hands of an all-powerful Other whose arbitrary law forbids access to it. This is why the subject will devise elaborate neurotic scenarios to lure the Other, to defend against it, or even to claim responsibility and guilt so that the fantasy can remain intact. The process of psychoanalysis consists in coming to realize that the Other, whose *jouissance* we both fear and envy, in fact resides within us—not as all-powerful or malevolent, but simply as traces, as a legacy of the marks of psychic separation from the primordial Others of our childhood. This legacy that we encounter through the analytic process is precisely what Lacan called *castration*. Therefore, the process of

revisiting a castration that has been there from the start enables us to realize that the fantasy leading us to fear the retaliation of the law was merely an artifact—one ultimately devoid of meaning.

This theoretical model serves as a kind of boilerplate through which clinical vignettes can be told. The advantage of this model, from a Lacanian point of view, is that it provides an opportunity to suspend the always complicated question of diagnosis. The dialectical relation between the signifiers of the desire of the Other and the oedipal fantasy that assures its functioning is always played out in the transference, even in cases of more severe pathology. What may be modified in the latter could be related to the intractable nature of the fantasy and the poverty of the signifiers assuring its existence. The intervention of the analyst in the transference in such cases may be of a different nature than in classical neurosis. And even though the direction of the treatment may be radically different, the Lacanian reading of the prohibition of incest continues to function as the compass informing the analyst's interventions.

This model can be applied to our work with most analytic patients, even those presenting borderline or narcissistic disorders, as the following clinical presentation illustrates. The efficacy of this model resides precisely in the fact that it resists the necessity to focus on diagnosis. The transference will serve as a guide for determining the types of intervention required, and these can include a range of possibilities. It is important, however, to emphasize that such interventions must be determined as well by the analyst's assessment of the extent to which symbolic castration has been sufficiently established to allow the formation of unconscious fantasy, which can in turn be deconstructed through the analytic process. It often happens in more severe pathologies that the analytic work does not consist so much of uncovering such a fantasy as of the offer, through the transference, of new landmarks for the patient—landmarks that in turn can feed the fantasy and give the patient new trust in his or her ability to follow the path of desire (a conceptualization not dissimilar to Kohut's [1971] selfobject). This requires that the

analyst offer the patient much more than transference interpretation: the person of the analyst needs to be lent, so to speak, to the patient as a space through which new unconscious connections can be created. This may entail very active interventions, and more specifically, the analyst must authorize her- or himself the freedom to invent.

The model presented above serves as a guide for determining the extent to which the patient has been able to translate the *jouissance* of the Other into signifiers of the desire of the Other. When such landmarks have been missing at crucial moments of childhood, the *jouissance* of the Other overwhelms the patient's ability to access desire.

CLINICAL VIGNETTE

Sally came to analysis with one of us at the age of forty-five. On first contact, she told the analyst that she had just come out of a failed analytic experience, during which she had remained silent for about two and a half years. Her former analyst, exasperated, had finally decided to end the treatment.

Sally did not appear to be either violent or resistant, but only very anxious, and I (the analyst) was intrigued by the fact that she had not been completely discouraged by her previous dramatic analytic experience. I sensed that Sally could easily become mute again, and knew that consequently, treatment would not be simple. In fact, I feared that Sally might be unanalyzable because she constantly experienced the feeling that she was going through something that could not be communicated through common language. Everyday matters were almost impossible for her to manage, and moreover, she felt incapable of explaining why these daily events were so painful and difficult to bear.

During the first part of the analysis, Sally could report only past events that seemed hardly meaningful to her. She expressed hatred for both her parents, describing her mother as an intrusive and obsessional woman who could not understand her daughter, and who had at times been violent toward her when

she was a child. Together with her older sister, the patient had formed an alliance against the parents, and although her sister seemed at first to have been helpful, it later appeared that she resembled the mother and was not a reliable figure.

What appeared to have saved Sally's psychic life was the fact that she and her family moved to Africa when she was six years old, and there she was "adopted" by a tribe of natives. Her parents knew nothing of this connection. The family returned from Africa when Sally was twelve years old, whereupon she was seized by such anxiety attacks that she could not sleep at night. She thought that she might die at any moment, and believed that she could not communicate to her sister—the person closest to her—any of what she was feeling. Her college studies finally saved her, because they enabled her to leave her parents, even though she was terrified of the required exams and felt isolated from everyone. Nevertheless, she managed to graduate and became a professor, and was quite successful in her work with students at the time she initiated this, her second, analysis. However, she had essentially no relationships with colleagues. She formed friendships only on the condition that she would listen to the other person, but would never talk about herself, since doing so caused so much anxiety that she came close to fainting.

Early in the analysis, Sally asked if the analyst could be the one to start talking, rather than she, because she was so afraid of beginning any sort of conversation, and because she wanted never to speak about the difficulties of her everyday life. I complied, commenting that the patient needed to make sure both that I remained the same, and that I had adopted her unconditionally, just as the African tribe had during her childhood.

With the little that the patient told me, I had to reconstruct her history. Here and there, she brought in new pieces of information and showed some interest in my efforts. Since I was unable to access the affects that had informed her past experiences, however, and since nothing of value seemed to be emerging, I was obliged to find a device to get her engaged. I knew that her favorite book was a classic of French literature, written by an

author whom I did not like; nevertheless, I forced myself to read the book in order to discuss it with her. Sally then experienced some pleasure in speaking about this book with me, yet at the same time, she feared that this pleasure would turn against her—because if the analyst disappeared, she would not know how to deal with the loss.

It happened that, just at the time that we were discussing the book's author's thoughts about her mother's death, Sally's own mother died. Sally did not go to her mother's funeral. Given the presence of a severe rift between the families of her parents, her nonattendance allowed her father's family to speak to her for the first time. The patient then learned from them that her father had never loved her mother, and that the two had been forced to marry because her mother was pregnant with Sally's older sister. Sally felt relieved to find some explanation for the fact that her father had never loved his children. He always ignored them, and as a reaction to the hatred he felt toward his wife, he chose to live in a permanent state of submission toward her, including her terrible parenting. Sally also understood why her father had been violent with his older daughter.

In the first part of the analysis, I concentrated on reconstructing the patient's history on the basis of the bits and pieces she gave me. I tried to offer her narratives that she could use to make sense of the relationship between her mother and her grandmother, whom she loved very much, and to help her understand how this wonderful grandmother could have produced such a difficult and crazy daughter. I tried to limit her ongoing panic attacks, which were destroying her and making her depressed, especially when she observed my efforts to help her.

A most interesting aspect was the analysis of Sally's transference toward her analyst. After one year of analysis, Sally told me that she had found in me someone who *existed* and with whom it felt safe to talk, but paradoxically, she was still frightened at the idea of coming to her sessions. Yet she never missed a session and was never late. During that time, I clearly occupied the place of her sister, which was the best she could do at the time. Despite

their limited relationship, she had been the only one to whom the patient had spoken when she was little. This explained why nothing new appeared in her discourse at this time: her sister had ultimately proved to be not as safe as she had thought. In our work together during this period, it made no difference whether I interpreted the transference or not; in any event, nothing changed. Something else needed to happen.

In the second part of the analysis, we worked on the patient's favorite book, and Sally was very interested and surprised to see that something she had been teaching for years had become a whole new object of study. What she used to find uninteresting before—such as the author's idea of a kind of closeness that actually draws apart those who experience it, or that there is an embrace in death—eventually became problematized in her mind. Through a discussion of the book she loved so much, from which she eventually became detached, we were able to explore the strangeness of her social behavior. It is interesting to note that homosexuality was one of the latent subjects of the book—a theme that she had denied until then because she was so scared of it.

I did not interpret the homosexual transference because I knew it would be too traumatic, and that ultimately it would not help. Even though nothing was said directly about her relationship with the analyst, something of it could be articulated by analyzing the denial of homosexuality in the story. After that, Sally was finally able to share with her analyst her memories of some of the physical abuse that her mother had inflicted on her. She also told me that the only way to bear the abuse had been to imagine that she was dead inside.

This was the period of Sally's work during which her mother died, and as mentioned, she did not go to the funeral, creating the circumstance in which her father's family felt at liberty to give her the pieces of her family romance. We could then analyze how Sally had felt disappointed by her father's behavior, but I was never able to move beyond her resentment and her need to merge her parents together. She continued to think of her father as being as terrible as her mother had been.

My inability to separate the mother–father dyad—in other words, to introduce what we call the law of the prohibition of incest (Lacan 1977)—made me feel that the patient was trying to control me. I began to feel that the analysis had reached an impasse, and that she was resisting my attempts to break down her *jouissance* and to translate this *jouissance* into a feeling of loss that would enable her to access something of her desire. She could neither mourn the fact that her father could not love her, nor accept the limitations and despair of her own mother. I became fed up and felt very angry with her, growing sick of my role of analyst *qua* literary critic. I told her that I was tired of talking about the main character in the book, and that it would be better for her to tell me what was bothering her in her life at the time —something she had begged me not to insist that she do.

Miraculously, Sally agreed to tell me something I could not possibly have imagined: that she had become a surrogate mother to one of her friends, a woman who talked to her without requiring that Sally share anything, and who was, conveniently, a severe alcoholic. The patient reported that this friend had gotten much worse, and that she felt she could not handle the relationship any more because her friend had become exceedingly dependent on her.

It was obvious that Sally had deliberately hidden this fact from me. She had been caring for the friend for years, but had never told me about her. She said she thought that telling me about this would make no difference, because there was nothing I could do about it. In fact, her silence was hiding a very aggressive move on her part. She wanted to deprive me of the opportunity to show her that I could be a better parent than she herself was toward her friend, and moreover (something she must have sensed), she had been depriving me of the opportunity to demonstrate that this friend was an incarnation of Sally herself, and that she was trying to take care of herself by becoming to her friend the parent she had never had. By the same token, in doing so, the patient was trying to express her opinion that all our work together was of no other value than to show me—in-

directly, of course—that I was as lethal and ineffective as the figure of her parents combined.

This time, I did not hide my own anger as I hit her over the head with my interpretations. For the first time, Sally was able to recognize that instead of being a passive victim, she had been an active agent, and that she had in fact set up the whole scenario. This recognition had the strange effect of empowering her, as she enjoyed both the insight and the sight of my anger, which not only proved to her that I cared, but also allowed her to see what castration was like, something she had never understood before. *Castration* in this case means that power is not where one imagines it to be—here I was not powerful enough to read her mind, but once I found out about her friend, I was able to refer the friend to a clinic that cured her relatively quickly. So, on some level, I was able to show Sally that I could be a good parent, since her friend was an incarnation of herself, but also that one can only function as a good parent if the Other says something about what is wrong. Castration reveals the transformative value of speech.

Despite this analytic work, we were both surprised to see the panic attacks Sally had had at the beginning of the analysis start up again. This gave her the opportunity to say something about what happened to her in her daily encounters with her co-workers. She told me that nothing scared her more than small talk. When there was nothing specific to say to her colleagues, and she could talk only about the weather, for example, she became terrified. I asked her what other fears she could connect to these experiences. She thought of her fear of heights, of being alone in houses that are too big, and her fear of spiders.

I then asked Sally to speak more of her fear of spiders. It had started in Africa, where she was terrified of the indigenous big spiders, although they were not dangerous. She also related two horrible dreams about spiders. In the first, she saw on a wall millions of moving spiders' legs. As she told me this, I saw her brush something from her jacket with her fingers, yet there was nothing visible there. I did not say anything, but

merely listened to the second dream. Here the body of a spider was made of hard clay, out of which emerged some fragments of bones. This vision was so awful that she could barely utter it.

I told the patient that this image made me think of death, which is a terrifying thought, and that the body of the spider seemed to represent a corpse. I added that if the two dreams were linked, they seemed to speak of the fears of a little girl—the first evoking the small fingers of a child (legs of spiders moving on a wall), perhaps asking for help with the idea of death. I then reminded her of her gesture of brushing her fingers along her jacket. I noted that perhaps the little girl felt afraid because she did not have any answers.

At that moment, Sally remembered that the tribe in Africa had taken her to the place where their ancestors were buried, the first place where she had seen bones. She then recalled that before she had gone to Africa, her aunt's baby girl had died suddenly. The baby had the same name as Sally herself, and she remembered everyone's saying that the baby died for no reason, which terrified her. I told the patient that she may not have been able to understand at the time how this baby, who was not bad or mean, could have died inexplicably. Did she think the baby's parents had had something to do with her death? At least in Africa, the dead people whose graves she saw had died for a reason. It may have developed that for Sally, small talk resembled that which makes no sense, just like the baby's death.

At this time, Sally said to me, "I always thought that spiders represented my mother, but now I can see that spiders must represent a kind of death that is frightening because it makes no sense." Thus, we see here what is often the case: that the function of the phobic object is to protect against that which makes no sense, and at the same time, it carries the trace of what is most frightening. Sally remembered that her parents had been quite indifferent when the baby died, to which I remarked that indifference is not a feeling that a child can decipher, and that what she was now referring to as "indifference" was actually the confusion she must have felt at not knowing which position her

parents occupied. Were they on the side of the baby or against her?

Sally then told me that never did her parents appear to her as being on the side of the protectors. She said that she experienced the same fear and confusion when her mother, who had also been her teacher in primary school, had asked her to read aloud in class. She had felt mute and incapable of reading. The patient analyzed this scene and concluded that she had been mute as a way to show the others how dangerous her mother was. I told her that under the gaze of the audience, she must have felt that her mother's violence could be neutralized. Sally then recognized for the first time that her silence was also a way of asking her mother for help, and that this related to my intervention of the little hands in the dream.

The patient also remembered that the text she was asked to read in class was about Pinocchio, and that she had somehow convoluted the story in her mind to be one of a real child who had been transformed into a wooden puppet, instead of the other way around. I reminded her that in the story, it is the father of Pinocchio who is hoping to bring life to his child, but in her own story, a father can only transform a living child into a dead one. At that moment, she said, "I remember that my father used to work with wood, and I complained that he spent more time in his workshop than with us." I commented that she might have been hoping that her father would be different from her mother: "Remember how relieved you felt when you found out that your father had been forced to marry your mother? And also that the word *indifferent* referred more to your despair at the discovery that, faced with the death of a baby, your father had not been different from your mother—which explains why you turned Pinocchio's story around." The father, like the mother, would transform a living baby into a wooden one.

CLINICAL DISCUSSION AND CONCLUSION

This case highlights the fact that psychoanalysis must always be oriented toward the same goal, which is, as Lacan (1977) wrote,

"that *jouissance* must be refused so that it can be reached on the inverted ladder . . . of the law of desire" (p. 324). In Sally's case, the analytic work was devoted to finding strategies that permitted the patient to give up the *jouissance* of being dead, which in the patient's mind served as both a protection against desire and a replacement for what she imagined desire to be. The challenge for the analyst in such cases is to break down the pathological appeal of this *jouissance* and to show that limiting its effects has a much more protective value than letting it run its course.

A new map of clinical diagnostics could be drawn based on this idea, according to the intensity and the difficulty a patient has in giving up her or his attachment to the pull of such a *jouissance*. It is important to note that the patient presented here does not fit a classical model of neurosis. The goal of this analysis was not to demystify the power of fantasy, but precisely to reestablish a neurotic structure in which desire was attempting to fulfill an oedipal wish. Discussion of this patient from a Lacanian perspective is illustrative not only of a more disturbed patient's psychic disarray, but also of how one can successfully use Lacanian conceptions in a way that is compatible with recent trends in American psychoanalytic theory.

If we study Lacan in the context of other psychoanalytic ideas, we discover that one of his questions—once he had exhausted the different ways of exploring Freud's theory of the Oedipus complex and the various neurotic structures—was how to deal with borderline disorders. Lacan's anti-Anglo-Saxon tendency prevented him from incorporating into his work the latest discoveries of object relations theory, intersubjectivity theory, self psychology, and so on, all of which were devoted to understanding how psychoanalysis could be used when the classical model no longer worked.

However, it is important to note that from a Lacanian perspective, it is not enough to see transference as a process that repairs the deficient childhood experiences of the patient. What matters in the experience of transference is that the analyst is

able to introduce the law of the prohibition of incest through whatever means he or she can discover. Lacanian analysis is in accord with certain trends that are critical of the neutral stance of the analyst, but not with the idea that the analytic experience does not have a specific compass, one that consists in constantly attempting to cut through the *jouissance* of the other in order to expose the redemptive nature of the signifier. Yet what Lacanian psychoanalysis does not explicitly say is that without trust, there is no possibility of making use of those signifiers. When Sally's analyst became angry with her, the analyst was feeling not only the patient's anger, but also the frustration of a "good enough" mother (Winnicott 1956)—one who could not stand to see self-destruction operating in her child (made apparent by the fact that the patient had unconsciously sabotaged the analytic work).

Once trust has been established in the analytic relationship, it is possible for the clinician to function as the neutral analyst whose job is to interpret and intervene at the place where *jouissance* obscures the possibility of separation. What has been crucial for Sally's analyst (and the treatment is far from over) is the process of helping the patient to both retrieve and to fabricate her oedipal fantasy. As is often clinically proven, the moment the feeling of loss is experienced, it becomes possible to elaborate a fantasy in which the Other can be all-powerful in a positive way. In Sally's analysis, the transformation from the spider to little hands begging for help was the key moment at which, for the first time, the patient could feel herself to be detached from her mother, and yet simultaneously in a position of desiring something from her.

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DOES THE CURE COME AS A BYPRODUCT OF PSYCHOANALYTIC TREATMENT?

BY MARILIA AISENSTEIN

Successful psychoanalytic treatment accomplishes more than symptom relief; it involves a psychic restructuring that is facilitated by the process of working through. The author reviews Freud's original description of this process and traces its evolution since then. Application of the psychoanalytic method as an appropriate therapeutic modality for non-neurotic patients is illustrated through the presentation of a clinical vignette.

"Does the cure come as a byproduct of psychoanalytic treatment?" —a well-known query, at least in French psychoanalytic circles— has often been attributed to Jacques Lacan. However, it was originally Freud's (1923): "The removal of the symptoms of the illness is not especially aimed at, but is achieved, as it were, as a byproduct if the analysis is properly carried through" (p. 251). This theme was later only brought to light by Lacan (1966, pp. 324-325). Lacan practically made an imperative out of it: the psychoanalyst must not interest him- or herself in therapy, a position that has long influenced psychoanalysis in France.

In my opinion, it is a mistake to attempt to separate the therapeutic and the psychoanalytic processes. Freud (1933) insisted on the value of *truth* in psychoanalysis, and for him, this truth represented the basis of treatment and improvement. He elaborated:

> As therapy, psychoanalysis is one among many, though, to be sure, the first among equals *(primus inter pares).* If it

> was without therapeutic value, it would not have been discovered as a result of contact with sick people, and would not have gone on developing for over thirty years. [p. 157]

Today, seventy years after Freud wrote these words, we can confirm the therapeutic action of psychoanalysis, even when it does not concern itself with a cure per se. If this were not the case, this difficult and costly method of treatment, so constraining for the two protagonists, would have disappeared. Our aim, therefore, should not be to define the therapeutic action of psychoanalysis, but rather to try to explicate the essence of the power of the psychoanalytic process to produce what might be called "a better way of being in the world"—a process not limited to the elimination of symptoms.

I remain today a passionate reader of Freud, whose ideas exhibit an overwhelming timeliness. For him, as a neurologist, it was the resolution of the conversion symptoms of hysteria that gave rise to the model of psychoanalysis as therapy. In his "Introductory Lectures to Psychoanalysis" (1917), he clearly set forth how the neurotic person indulges and enjoys his or her desires in unconscious fantasy, and how these find expression in the symptom. Renunciation does not come easily. The study of resistances led Freud to an economic concept of mental functioning. The development of his concept of narcissism (1914a) led him to revise his theory of drives, at the same time that it extended his field of clinical observation to the psychoses, the perversions, and hypochondria.

After 1920, it was generally thought that the therapeutic action of psychoanalysis does not consist merely of the cure of neurotic symptoms, but rather includes the notion of *psychic reorganization* and change. Similarly, in the cure, the wider notion of *psychic elaboration,* in my opinion, replaces the idea of the working through of resistances. I believe that the former is a therapeutic factor, in a very classical sense, as previously described by Spinoza (1677), who framed it in terms of human growth.

One of the last works of F. Scott Fitzgerald (1936), "The Crack-Up," comes to mind. It begins as follows:

> Of course all life is a process of breaking down, but the blows that do the dramatic side of the work—the big sudden blows that come, or seem to come, from outside, don't show their effects all at once. There is another sort of blow that comes from within . . . . the first sort of breakage seems to happen quick—the second happens almost without your knowing it but it is realized suddenly indeed . . . . the test of a first-rate intelligence is the ability to hold two opposite ideas in the mind at the same time, and still retain the ability to function. One should, for example, be able to see that things are hopeless and yet be determined to make them otherwise. [p. 39]

It seems to me that these words are very close in spirit to those considered by Freud, in his later works, to be proof of the efficacy of psychoanalysis: the quest for truth and the rejection of illusions.

THE EVOLUTION OF THE CONCEPT OF WORKING THROUGH

The notion of *working through* is related to that of psychic work, and is connected semantically to the word *labor* and to the expression *tilling the soil* (the French word *labour).* These aspects of working through form the base, the foundation, and the soil from which the drives originate (Duparc 1998). This metaphor of labor on the land suggests the somatic root of the drive. The German term used by Freud *(durcharbeiten)* also includes the idea of work, as well as that of a voyage. The English translation of *working through* is perfectly appropriate.

In "Remembering, Repeating, and Working Through" (1914b), Freud did not, strictly speaking, link working through with remembering; rather, he assigned it a separate status and made an analogy with abreaction in hypnosis therapy. "The principal resistance to psychoanalysis," he wrote (1914b), "is enacting the repetition played out in the transference which substitutes for remembrance" (p. 151). It is interesting to note that in this article, Freud

first used the term *repetition compulsion,* which he would take six years to better define. The appearance of this term preceded a passage in which Freud pointed to the difficulty of a worsening of symptoms at the beginning of treatment. He described the essence of psychoanalysis as the analysis of resistances that are nourished by repressed drives—and here Freud revealed himself to be poised between two theories.

All this became more complicated after 1920 and the introduction of the structural theory. The notion of the resistance of the ego no longer sufficed to account for the clinical difficulties encountered. Counter to all logic, there could be enigmatic resistances from the id—an indisputable clinical fact. These resistances are precisely the ones that require working through. And if Freud's definition of working through continued to evolve after 1920, this evolution became even more pronounced under the influence of Winnicott (e.g., 1952), Bion (1967, 1991), and Green (1990, 1993).

Because the transference itself is partially a resistance, and since "repetition played out in the transference . . . substitutes for remembrance" (Freud 1914b, pp. 151-152), the transference constitutes a means of access to the repressed. In fact, analytic work with non-neurotic patients leads us to redefine the concept of transference, and lends added significance to the notion of working through the analyst's countertransference—which no longer confines itself to the affective and negative effects of the transference from the patient to the analyst, but extends to include the entire spectrum of the patient's psychic activity.

I offer the following example of this kind of analytic work, conducted with a very difficult patient in a state of peril.

CLINICAL VIGNETTE

A young man, whom I will call Vanya, arrives one day for his session. I hear him coming up the front steps, and then nothing. Surprised at not hearing the doorbell, I hesitate to go to the

front door. I think I hear footsteps, but only very faintly. Four minutes later, the phone rings, and I hear Vanya's voice on my answering machine: "You have forgotten me, and so I am going away. Call me to let me know if . . ." By the time I pick up the receiver to speak to him, he has already hung up.

I rush to the front door and see him through the glass panel —running like a hare, cell phone in hand. I am troubled, and my uneasiness increases when my cleaning lady arrives a few minutes later, exclaiming, "What did you do to the young man who just left? He was running like a madman, and he seemed desperate."

All kinds of crazy ideas go through my head—among others, that I should catch up with Vanya in the street or call him on his cell phone and urge him to return. I do not understand what prevented him from ringing the doorbell (beforehand, I made sure that it was functioning properly); he has been doing it for years. I conclude that something must have happened, something that I must trace back to the preceding session.

Presently, I decide to call Vanya at home, where I reach his secretary. I leave a message with her, noting that I received Vanya's phone call, that it was time for his session, that I was there, and I would expect him on the coming Monday as usual. The secretary assures me that she will give him the message, and on a slightly anxious note, adds that he has not been well since the previous day.

I then begin to review in my mind the preceding session with Vanya in as much detail as possible. What I reflect upon is hardly remarkable, except for a short emotional interval, an unusual one for me with him: He had irritated me (although I obviously kept my annoyance to myself) by crying at length as he described how "very unhappy and very much alone," how "lost and abandoned," he had felt while returning home recently on an airplane flight. Knowing that this flight was on the Concorde (on which I have never flown)—which the patient had chosen to take precisely so that he would not miss a session—I was both curious about the details of the flight and annoyed by his plaintive tone.

Moreover, Vanya had undertaken this trip in order to buy a painting, another factor that aroused my curiosity. It developed that he bought it simply because someone had recommended it to him; in fact, he was indifferent to it, since he never paid attention to his living space. Deciding not to pursue any allusion to the patient's having taken a flight that figuratively abolishes time, I instead questioned him about the painting. He replied curtly, "None of your business."

The only condition I was aware of to which Vanya might have been hypersensitive was one stemming from the perceived emotions of the interlocutor. For example, he had once abruptly left a store in a rage, just because he did not feel welcomed by the salesclerk. Now, after his failure to ring the doorbell at my office, I reconstruct that Vanya must have unconsciously registered my momentary ill humor in the previous session without being able to acknowledge it, because in the past, when he has thought he noticed my mood, he has always expressed his perception of it to me. I then think of Winnicott (1952), who wrote of "failures of the frame" (pp. 74-75) as being failures of the analyst (that is, failures of the internal space of the analyst, which reactualize and bring about the reliving of an early bad holding environment). According to Winnicott, these failures can be interpreted if they are reintroduced into the material. I tell myself that I must do something about all this with my patient.

At the following session, when Vanya mentions nothing of what transpired, I ask him what happened. He begins by insisting that he does not remember not coming to the session. When I tell him my memory of the event, including a description of his message on my answering machine, it all comes back to him. He is astonished, and tries to minimize the incident. When I persist, he tells me that, once he was back home (and feeling rather out of sorts), he received my message; he was pleased that I was worried, and proceeded to have a good weekend.

Then Vanya tells me that he does not really know why he did not ring my doorbell. He was not feeling well, he continued, and expected that I would open my door to him in person—"yes,

you would be standing behind the door." But somehow, he became convinced that I had forgotten him, and so he had lived through a catastrophic experience.

I ask: "Did you think I had forgotten you while I was in my office, or did you think that I had gone away?"

"I knew you were here," Vanya replied.

I think of primal scene fantasies, and suggest to the patient that he imagined I might have forgotten him because I was thinking about someone else. "No," says Vanya in a calm tone that does not seem to match his contradiction of my comment. He adds, "How can I say it—-I was sure you were here, and at the same time"—he searches for the right words—"you had disappeared."

I point out to him that it was he who disappeared, perhaps in an attempt to make me experience something that he himself was living intensely. I then go on to suggest, as I have often done before, that he must have had similar experiences as a child. As usual, he replies that he *wants* to believe me, but since he does not remember anything like that, my interpretations are of no use to him. (He can be rather cutting at times.)

I then try to interest Vanya in a discussion of the session preceding the one in which he "disappeared." He does not remember it, and when I remind him about the account of his return flight, he recalls that at the end of that session, he had felt quite nauseated: "I thought I would vomit." As I think back to my feeling of envious irritation at the time, I note to myself that I had indeed been "nauseating."

Since Vanya is in the habit of communicating all his bodily sensations to me during sessions—in order to permit us to translate them into a language that he can remember and reflect upon —I ask him how he accounts for his nausea, and why he did not tell me about it at the time. "I feared that it would irritate you," Vanya replies. Then he laughs, and elaborates: "You are very shrewd, but so am I. I did not speak of it because I would have had to tell you that I had just had a meal in an excellent restaurant—which I thought it improper to mention, since I surmise that you must not have much time for lunch."

Thus, Vanya had sensed my emotional reaction to his account of the Concorde flight, but had been unable to express it to himself, instead experiencing physical discomfort, which he suppressed. He was consciously unaware of the envy, which he displaced onto another portion of the material; but at the same time, he had an inkling about it, although he was unable to put it into words.

DISCUSSION

Can we assume that this interaction with Vanya involved the projection of an affect lived out in physical sensations? Is this an example of an emotional projection that moves about freely, like free energy, exerting an effect on any material that comes up within the frame of the session? In fact, these projections or displacements of affect onto the sensory system in a concrete manner are very much present in psychosomatic clinical work. To give a second example, they came up with another patient of mine—a woman who told me that, whenever she felt stomach pain or discomfort, she would ask herself if she had some reason to be sad or afraid.

To return to the sessions described, Vanya is not a somatizing patient; on the contrary, he is almost disturbingly robust physically, and that is why his nausea was significant. Ferro (2000) described "microtransformations during the here and now of the session" (p. 72), constantly capable, thanks to a series of aftereffects, of modifying how the material is understood. I think that these aftereffects *(après coup)* are frequently located in the analyst's mental functioning, and that they make it possible to break down an area of unconscious collusion between the two protagonists.

This entire conception of psychoanalytic work is quite different from Freud's (1914b) definition of psychic working through. It leads us to reconsider the work of interpretation—which, far from having a bearing only on resistance, consists in connecting and disconnecting elements from a field of thought cogenerated

with the patient. Thus, the evolution of psychoanalytic thought is not restricted to the broadening of the clinical field to increasingly difficult and more atypical cases; indeed, it also involves a change in the aim of psychoanalysis. The purpose of clinical analytic study and research is the elucidation of the outcome of two discourses intertwined in the space of the sessions that limit the frame.

Is it not the convergence of these ideas and their impact on our daily practice that give rise to somewhat different notions of *working through* and *interpretation?* The analyst's decision to abstain from interpreting is based on the extent of the gap between that which the analyst is able to communicate and that which the patient is capable of receiving from the analyst. When the analyst not only reveals a hidden meaning behind a symptom, but also cocreates a previously absent meaning with the patient, we must reconsider our view of the mechanism of therapeutic action. The potential benefits of psychoanalysis are not easily reduced to an explainable symptomatic cure, bearing in mind that such a cure, according to the classical medical model, is defined as a return to the previous state. Therapeutic action must instead be understood as a movement toward growth in the psychic field.

Freud's (1938) final concept of Eros and the death drive should, I believe, be understood as an attempt to give metapsychological status to the process of thinking and thought. His final theory of drives was conceived in order to make room for the concepts of narcissism and the destructive drive, whose scope he had previously failed to appreciate. Clinical failures led him to relate the problem of the negative therapeutic reaction to trauma and psychosis. The development of the concept of narcissism and the discovery of the compulsion to repeat propelled Freud "beyond the pleasure principle" (1920). His view of the death drive as contrasting with the libido, which combines sexuality and self-preservation, is an interesting one; I believe, however, that the problem does not consist in knowing whether sexuality is properly placed on the side of life or death, but rath-

er in the appropriate repositioning of conflict within the very process of thought.

The success of modern psychoanalytic work is inconceivable in the absence of a theory of thought. Furthermore, I think it is crucial to place the issue of death at the heart of thinking itself, which Arendt (1978) characterized as "the dematerialized quintessence of living" (p. 204). Arendt viewed thinking and living as two identical phenomena, since mortality "forms the infrastructure of mental activity" (pp. 225-226).

Like the worm in the apple—a Freudian metaphor that places the seed of "actual neurosis" at the heart of all defense psychoneuroses—the tendency to destroy the work of thought resides within the bosom of psychic life. The depressive condition, the work of bereavement, and the work of mourning are harbingers of psychic working through, but should we not also conclude that at the heart of every depressive state, there could exist the hidden seed of a potential attack against psychic life itself, and especially against thought? Extreme examples of this destructiveness are mechanical thinking, a whole array of antithinking discourses, and other defenses seen in certain patients, such as borderline types, in whom the failure to identify with the primary object reveals the aftermath of an anti-thought process.

Since 1950, psychoanalysis in France has evolved under the sway of various influences, and in particular, that of Lacan, who by his dissent obliged non-Lacanians to justify classical technique (exemplified by the importance of the frame), and to redefine their reliance on Freudian metapsychology. The work of Winnicott and Bion has helped to promote an in-depth study of countertransference and of the psychic processes necessary to accomplish analytic work with atypical patients. With the introduction of new clinical concepts, such as *pensée operatoire* ("mechanical thought"), alexithymia, and essential depression (i.e., "without affect"), the Paris Psychosomatic School has brought to light an economic perspective of mental functioning. In addition, in his discussions of negative narcissism, destructiveness, and the notion of deobjectalization, Green (1993) has, in my opinion,

established a more fruitful and vibrant conception of the death drive described by Freud.

CONCLUSION

The brief clinical sequence presented here is intended to illustrate my belief that the psychoanalytic method is therapeutically valuable even with non-neurotic patients. The therapeutic effects for Vanya were not limited to the elimination of symptoms (e.g., compromise formations); rather, those therapeutic effects extended to the reanimation of the patient's frozen, immobilized psychic functioning, in order for him to again feel alive.

I subscribe closely to Arendt's (1978) theory that *to live* and *to think* are one and the same thing. This is the basis for my view that the therapeutic effects inherent in the psychoanalytic cure are irreducible and irreplaceable, and distinct from those of all other therapeutic methods. Psychoanalysis can lead patients, free from all suggestion, to see themselves as the subjects of their own stories and their own thoughts, and even of their own suffering. This is perhaps the human being's only inalienable freedom.

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DISCUSSION

The Several Relationships of Theory and Practice

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I

The question of how theory affects practice is fundamental to psychoanalysis. Repeatedly addressed in our conferences and our literature, it has led not to an answer but rather to an evolving dialogue that reflects the changes in psychoanalytic discourse and practice over the years. Freud himself was both a theoretician and a practitioner, and we are still debating whether his theory led to his practice, was derived from his practice, had more to do with nineteenth-century scientific ideology than with clinical psychoanalysis, was strangely disconnected from his practice—or whether, paradoxically and to varying degrees at different times—all of these have been true.

The ten contributions from psychoanalysts assembled here from around the world discuss several different types of theory. Some speak of the formal, public theories of psychoanalysis—those that are presented in our textbooks, discussed in our journals, and often associated with the names of leading thinkers in our field. Thus, we have Busch on structural theory, Smith on conflict theory, Ornstein and Ornstein on self psychology, Hirsch on Sullivan's interpersonal theory, Blevis and Feher-Gurewich on Lacan, and Ferro on Bion. Others emphasize the private theories that, although sometimes out of the analyst's conscious awareness, nevertheless mold his or her stance and approach (Michels 1999). Fonagy discusses Sandler's (1983) distinction between public and

private theory, while Reed illustrates the impact of theories on the precarious spatial metaphors that inform her thinking and her work. Rey de Castro discusses the several ways in which thoughts of theory enter his mind during his work with patients, and Aisenstein emphasizes the important distinction between the impact of theory on what the analyst believes he or she is communicating and what the patient is actually receiving.

One of the oldest distinctions in discussions of psychoanalytic theory is between general theory, such as Freud's metapsychology, and clinical theory. Are they closely linked or unrelated? Is one based upon the other, and if so, which on which? Is general theory outmoded? Is clinical theory really a theory at all or merely a set of empirical generalizations and technical guidelines? Does clinical theory describe what we do, while general theory explains why we do it?

In recent decades, there has been a shift of interest from general to clinical theory, as well as the development of new domains of general theory, with developmental psychology, cognitive neuroscience, and linguistics replacing the drive psychology and evolutionary biology of Freud's day. The authors represented here seem more comfortable with clinical than general theory, although they do invoke larger systems—ego psychology, self psychology, or the work of theoreticians such as Kohut, Lacan, or Bion for example, to explain their clinical orientations. However, they are concerned lest they impose a general theory on their data, and even more, lest they impose it on their patients. They recognize that theory can be understood as a contributor to countertransference (Grossman 1995). They are aware of competing general theories and are quick to avoid any claim of superiority of one over another. When they do suggest such a judgment, it is based on a greater degree of flexibility, minimalism, or openness to alternatives, rather than on absolute truth or correctness. The contemporary theoretical dialogue, at least in public, is far more ecumenical than dogmatic.

A more modern distinction—related, but not identical—is that between the clinician's theory and the researcher's theory.

Clinicians want help with their clinical work. They are concerned with the richness of a theory, the guidelines it might offer for interventions, the interpretive metaphors it suggests, the comfort it provides in difficult situations. Researchers want precision, clear definitions, testable hypotheses, concepts that can be operationalized, terms that can be translated to those used in other disciplines. Theories that are valuable for one might be virtually useless for the other. Fonagy wants to stimulate research in psychoanalysis and suggests that a more tentative attitude toward clinical theories might make them more useful for researchers. Most of the other contributors here write from a clinician's perspective; they either have little interest in systematic research or believe that if research is to be interesting or important, it must find a way to cope with those theories that are relevant to clinicians. A third role of theories, the ways in which they are employed by teachers, is not discussed here, although in the past, Lewin (1965) has suggested that this might be their most fundamental function.

Another related, but again not identical, distinction is between explanatory and hermeneutic theories—those that make statements about cause and effect, as contrasted with those that discuss and suggest relationships among meanings. Freud thought that his theories were explanatory, and most psychoanalytic theories have been formulated in explanatory language. Explanatory theories are more familiar rhetorically, more convincing, and friendlier to the thinking in many adjacent disciplines. However, philosophers and scientists have argued that regardless of their language, most psychoanalytic theories fail the critical tests to qualify as explanatory ones, and that analysts rarely study or evaluate them in the way scientists study explanatory theories. Rather, they use them as guides to interpretive strategies, that is, as hermeneutic systems.

This basic issue arises in discussions of psychoanalytic research such as Fonagy's, and is alluded to by those who are conscious of their theories and fearful of imposing them on their patients, such as Hirsch and the Ornsteins, but is rarely raised by those who de-

scribe their clinical work without directing attention to the theories they employ. Furthermore, there has been great interest in psychoanalysis from disciplines in which hermeneutic systems are commonplace, while postmodern critiques sometimes seem to collapse the difference between the two.

A final distinction between types of theories separates those that are about content—the patient's mental life or subjective experience—from those that discuss process—the events in the analyst's office. The first includes libido theory; infantile sexuality; separation-individuation; the paranoid, schizoid, and depressive positions; developmental models in general; narcissism; ego psychology; the bipolar self; dream theory; and so on. The second includes analytic process, resistance, interpretation, empathy, acting out, working through, the therapeutic alliance, and countertransference. There are, of course, concepts at the boundary—transference is a prime example; however, a great many theoretical formulations can be placed in one or another of these categories.

Once again, there has been a shift in emphasis in recent years, with greater attention to process, some of which had been subsumed under the "art" of psychoanalysis—that which "goes without saying," the "nonspecific" component, but which many now see as central. Hirsch, Ornstein and Ornstein, and Busch have a particular interest in process theory, and this is also prominent in the contributions of Reed, Ferro, and Aisenstein. Much of the contemporary analyst's discomfort with theory relates to the status of content theories—if the process theories describe a strategy for discovery, or perhaps construction, do the content theories tell us in advance that which we will find or create? Are they descriptions of what others have found before? Do they merely attempt to provide a language for describing our discoveries, while striving not to bias the search?

The modern analyst is situated in a dilemma, often seeming to pretend to know less than he or she believes is true, in order to avoid questions of epistemology or accusations of authoritarianism. The analyst would like to think that he or she ap-

proaches the patient without preconceptions, but knows that this is not possible. The analyst is troubled by the paradox that he or she is supposed to learn a great deal in training, but then forget it upon entering the consultation room—only to discover it anew with the patient. He or she is particularly troubled to recognize that each analyst seems repeatedly to discover that which he or she had learned before, and that it is far easier to predict what will be discovered if one knows the analyst and his or her favorite theories than if one knows the patient and his or her problems (Bion 1967).

II

The theme of this issue is the relationship between theory and practice, and the contributors give varying emphases to each of these. At one end of the spectrum, Fonagy's paper is metatheoretical, that is, it is about the function of psychoanalytic theory in general, rather than about any specific theory. His goal is to encourage psychoanalytic innovation and inquiry, and in order to do this, he wants to liberate practitioners so that they can experiment with new techniques. At present, they are inhibited from doing so, he argues, because of the false belief that current "standard" practice is derived from our basic theory. Such a view may be politically expedient, but Fonagy argues that it is demonstrably false. Our clinical theories are no more than generalizations of previous clinical experience. He accepts that theory influences technique, but suggests that its influence is not based on any logical relationship between the two.

Freeing the practitioner from the political and psychological bonds of adherence to public theory, as well as recognition of the power and potential of individual private theories, should lead to creative innovation in technique and valuable inquiry into the treatments that result. For Fonagy, core psychoanalytic theory is about process, not content. Furthermore, there is one type of core theory—clinicians and researchers work with the same theories. Finally, his primary goal is to advance the field;

he expresses no concern about maintaining standards or diluting the discipline by blurring its definitions or making its boundaries more porous.

Smith offers a study in comparative theory. He selects a specific core concept, that of conflict, and traces its role in the thinking of Freud, his French and North American followers, and six contemporary analysts. He discovers significant differences, even among members of the same school, and hopes to offer a strategy for integration—in effect, the resolution of conflict about conflict. He believes that different views of conflict lead to different technical implications, suggesting, one might think, that the acceptance of an integrated view should decrease the technical differences among the various schools. He discusses differences not only in theory, but also in the role of theory in the analyst's clinical work, as when he contrasts evenly hovering attention with the "more deliberate focus" of Gray's "close process attention." Smith joins with Fonagy in arguing for a "looser coupling of theory and practice" (p. 83), with practice leading the way and theory following behind.

How will these innovations in practice that are not based on theory occur? We know that they cannot be independent of all theory; practice without theory is impossible. I suspect that what both of these authors are advocating is a more powerful role for private theories and a corresponding weakening of the authority of formal, public theory—an authority they believe has inhibited progress in our field.

Rey de Castro argues that by their very nature, psychoanalytic data cannot be encompassed by clinical theories, that primary unconscious processes are impossible to describe in secondary-process language, and, therefore, that psychoanalysis is inevitably uncertain. The cases he presents emphasize his varying experience of theory in the clinical situation. In one, he is flooded with thoughts of theory and must choose between disparate levels and contradictory theories. In another, he reports being preoccupied with the patient's symptom and his experience of a "desperate" search for theory. He finds it necessary to try to reconcile con-

cepts from different schools, with a resulting eclecticism that he views as a necessary evil rather than a desirable integration. Clinical theory, for Rey de Castro, must be linked to a metapsychology, must be incomplete, and must lead to knowledge that is tentative and hesitant. He sees multiple clinical theories as inevitable and the clinical work of psychoanalysis as incompatible with certitude.

Reed, like Rey de Castro, is interested in how the working analyst experiences theory. However, in her case report, she emphasizes how her conscious attention to this process helped her to recognize the preconscious metaphors that had guided her relationship with the patient, allowing her to reorient that relationship in a more useful way. Reed sees such metaphors as immensely powerful, to the extent that a shift in metaphor may lead to a shift from the primacy of a focus on verbal data to that of a focus on nonverbal subjective states, which can be taken to refer to "mental states of the subject in relation to the transference object" (p. 119). She discusses a theme that recurs in other articles in this issue: the greater role of such data and strategies in work with non-neurotic (i.e., more disturbed) patients.

Each of the six remaining papers focuses on the theory of a particular school or thinker, as illuminated by work with specific patients. Ferro is influenced by the teachings of Bion. He describes a difficult patient, and conceptualizes his work in terms reminiscent of Reed's: "Two levels of communication were taking place between us: one superficial—totally shallow—and another carried out via projective identifications" (p. 187). He describes the extensive preinterpretive emotional work that was required before a more traditional interpretive analytic process could be effective.

Aisenstein also selects a "very difficult patient in a state of peril" (p. 266). She describes her reconceptualization of working through, as well as the shift of aim in her treatment from the elimination of symptoms to the "reanimation of the patient's frozen, immobilized psychic functioning" (p. 273). Her goal is that patients "see themselves as the subjects of their own stories and their own thoughts" (p. 273).

Blevis and Feher-Gurewich work within the Lacanian tradition. They summarize Lacan's view: "The process of psychoanalysis consists in coming to realize that the Other . . . in fact resides within us—not as all-powerful or malevolent, but simply as traces, as a legacy of the marks of psychic separation from the primordial Others of our childhood" (p. 249). They add that, in more severe pathologies, the analyst must "offer the patient much more than transference interpretation: the person of the analyst needs to be lent" (p. 251). The patient they present has such pathology —she had been mute for two and a half years in a previous analysis. As Ferro does, they describe a preinterpretive phase, one conducted in accord with a Lacanian model, which entails strong emotional interactions between therapist and patient, and which establishes an underlying trust essential for subsequent interpretive exploration of the transference.

Busch argues that theory governs everything the psychoanalyst does, even "the smallest detail." He sees psychoanalysis as working by helping patients to understand their minds, and bases his technique on the structural model of the mind. He focuses on the patient's free associations; other sources of data are secondary. Like Aisenstein, he differentiates what the analyst believes he or she is saying and what the patient actually hears. He agrees with the others that the analysis of countertransference becomes particularly helpful in managing the patient's enactments, but as a general principle, he prefers to work closely with the patient's associations, avoiding the analyst's speculations and inferences. As one might expect in view of his preferred technique, he presents a patient considerably healthier than those of Rey de Castro, Reed, Ferro, Aisenstein, or Blevis and Feher-Gurewich; one wonders to what extent this reflects his selection of cases and to what extent it reflects the influence of theory on shaping his perception of the patient.

Hirsch is particularly concerned with the dangers of theory, especially its tendency to homogenize patients and compromise their unique individuality. He speaks of "theories that their pro-

ponents wish were not theories" and "dialectical tension—between theory and naive perception" (pp. 218-219). He views "observing-participation" and "subtle, affective, interactional factors" (p. 220) as more important than theory. (I might consider that to be his theory, but he seems to restrict the term to abstract, complex, formal theories of mind.) In spite of these views, he goes on to formulate a rather specific relational theory, hypothesizing universal themes of unconscious mental content and a related theory of pathogenesis, a theory that he believes is supported by research in child development. Like Busch, he wants to emphasize direct observation rather than inference and speculation, but for him, unlike Busch, this means observations and accounts of the patient's interactions with others, rather than free associations. He presents two cases, both currently in treatment and engaged, to illustrate his ideas.

Ornstein and Ornstein believe that theory "is inextricably intertwined with every element of the treatment process" (p. 159) and that, in fact, "every deliberate human activity is saturated with theory" (p. 160). Their theory, Kohut's self psychology, dictates that the analyst's evenly hovering attention should be directed (a seeming paradox) toward vicarious introspection, or empathy. They postulate that a major element of the patient's mental life consists of selfobject transferences, and that the exploration of these will be a major theme of any analysis. They are concerned that the inclusion of explanatory theories (e.g., the Oedipus complex) in our notion of psychoanalysis leads to a closed system. However, they see the selfobject transference concept as fundamentally different from the Oedipus complex because it is based on empathic understanding, rather than on an explanatory theory—and therefore view their belief in its inevitable development as different from a classical analyst's belief in the inevitability of the Oedipus complex. Their clinical examples illustrate their theory's emphasis on the central role of exploring the patient's responses to breaches in the analyst's empathy.

III

Where does the dialogue on theory and practice stand in 2003? First, we know that there is no practice without theory, no possibility of perceiving, understanding, or knowing without the active participation of the analyst's mind and the influence of his or her preexisting cognitive structures. Like subjectivity and countertransference, theory is ubiquitous and inevitable. Second, we recognize that there are several kinds of theories—all relevant to analytic work. We have long differentiated general theories from clinical ones.

There are implicit or private theories that come into and shape the analyst's thoughts as he or she works with the patient, as well as official or public theories that are so important to the sociology and politics of the profession, informing the analyst's conscious strategy, and often his or her attitude and stance as well. There are theories that deal with the contents of the patient's mind and lead to the analyst's anticipations (and often to his or her readiness to confirm them), as well as theories of the process that offer guidelines on how to conduct the analysis—and even guidelines about when to throw away the guidelines. There are theories that organize the researcher's inquiries and projects, but may be of little interest to the clinician, and theories that are of little interest to the researcher, but valuable, and at times comforting, to the clinician. There are scientific, explanatory theories, and there are metaphors clothed in the garb of theories.

Perhaps we are even beginning to develop theories that will help us distinguish the various types of theory from each other. Although this may at first seem confusing, it may actually help to clarify our previous confusion. Much of what has appeared to be disagreement about psychoanalytic issues may turn out to be misguided attempts to talk across the boundaries of various categories of theory while ignoring their differences. Just as theory guides clinical process, the study of how it does so may lead to new insight into our field.

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