*Psychoanalytic Quarterly, LXXVI, 2007*

# INTRODUCTION TO "COMPARING THEORIES OF THERAPEUTIC ACTION"

BY SANDER M. ABEND

From the early years of his work, Freud wrote with great assurance about the mechanism of the therapeutic action of psychoanalysis. As he learned more, and as his theories evolved accordingly, his confidence in his opinion about which aspects of psychoanalytic therapy account for its therapeutic effect apparently remained intact. This was so even though his understanding of what constitutes therapeutic efficacy developed and changed as his general theories about mental structure and psychoanalytic technique were modified and refined.

The subsequent appearance of alternative psychoanalytic theories has naturally brought shifts in their proponents' accounts of the pivotal aspects of therapeutic effectiveness. In the current climate of psychoanalytic theoretical pluralism, as we have come to call it, there exist quite substantial differences of opinion about this crucial aspect of our theoretical structure. In some quarters, at least, there is also acknowledgment that the certainty that characterized the early period of psychoanalysis's growth may have been unwarranted. Perhaps these changes in the culture of our field account for the upsurge in the last decade or so of papers and books that attempt to deal with the topic of therapeutic action.

This supplement of *The Psychoanalytic Quarterly* represents the coming to fruition of a several-year-long effort to address this increasingly complex situation. As the idea for this compendium was discussed and developed, it soon became clear that the scholarship required to present a balanced view of the literature of the many theoretical variations on this theme—not to mention that

required for clinical expertise in the kinds of practice advocated by different schools of psychoanalytic thought, essential to an evaluation of the validity of the positions on this topic—was beyond the capability of any single psychoanalyst. In consequence, it was agreed to collect and publish an array of viewpoints, with invitations to participate extended to a number of distinguished psychoanalytic scholars.

The first phase of this endeavor was to recruit eight well-known psychoanalysts to present what amount to position papers that reflect the psychoanalytic theories and cultures in which each one functions. These analysts were invited to extract from their knowledge of the segment of the psychoanalytic literature that represents their own theoretical affiliations a summary of the theory of therapeutic action to which they, and their like-minded colleagues, subscribe. Judging from the time it took for these papers to be completed and submitted, this task must have proved to be even more daunting than might be supposed, since in most schools of thought theories of therapeutic action are not spelled out very clearly, if they are explained at all. Each invited author was, of course, free to present his or her personal views on the subject, rather than merely reporting on the literature, with the assumption that individual clinical experience would influence judgments.

We were interested in obtaining a significant breadth of psychoanalytic perspectives, so we chose notable scholars from a range of locales. From Europe, we have essays by Marilia Aisenstein of France and R. D. Hinshelwood of Great Britain. From Latin America, we have papers from Cláudio Laks Eizirik of Brazil and Rómulo Lander of Venezuela. From within the United States, different affiliations are represented by the following contributors: Kenneth Newman, a self psychology expert; Owen Renik, who agreed to represent the intersubjective viewpoint; Charles Spezzano, who wrote about the relational position; and me, Sander M. Abend, with a discussion of modern conflict theory. Each of us has had a substantially different psychoanalytic education, and our affiliations and opinions reflect these differences, as leavened in each

case by experiences we have had in the course of our individual psychoanalytic development.

In the second phase of this project, another varied group of outstanding psychoanalytic scholars was recruited, likewise representing many schools of thought, and tasked with the careful study and discussion of the eight position papers. Each of these authors approached the task in accordance with his own scholarly attitude, and they have produced a set of discussion papers that will amply reward the reader's most careful attention. These discussants are Ricardo Bernardi, Jorge Canestri, Lawrence Friedman, Arnold Goldberg, Jay Greenberg, Otto F. Kernberg, Robert Michels, and Henry F. Smith—each of whose scholarly credentials are so well known as to require no repetition here.

The result is a symposium that reflects the diversity of today's psychoanalytic climate, and, we hope, one that will educate the reader and stimulate further scholarly writing on this most difficult and most important topic. With these brief remarks, I am proud to present *The Psychoanalytic Quarterly's* 2007 supplement on "Comparing Theories of Therapeutic Action" to you, our readers.

---

*245 East 87th Street*
*Apartment 17G*
*New York, NY 10128*

*e-mail: sabend@cyberpsych.org*

*Psychoanalytic Quarterly, LXXVI, 2007*

# THERAPEUTIC ACTION IN MODERN CONFLICT THEORY

BY SANDER M. ABEND

*Recognizing that principles of psychoanalytic technique and conceptions of the analytic treatment process follow from the theory of therapeutic action to which they are linked, the author notes the difficulty of coming up with such a theory in relation to modern conflict theory. After reviewing Freud's initial descriptions of psychoanalytic theory and technique, as well as his later elaborations and modifications, the author summarizes the contributions of Freud's analytic contemporaries and traces the emergence of later theoretical variability in the field. He then presents an overview of recent developments in the theory of therapeutic action, discussing in particular the contributions of Arlow, Brenner, and Gray.*

## INTRODUCTION

To outline the theory of therapeutic action associated with modern conflict theory is surprisingly difficult to do. In fact, the theory of therapeutic action of any school of psychoanalytic thought is rarely stated in an explicit, unambiguous form in the literature of the field. Instead, we usually find it necessary to derive it by implication from certain basic assumptions about what constitutes the structure of the problems in the analysand's psychology that analy-

---

Sander M. Abend is a Training and Supervising Analyst at the New York Psychoanalytic Institute, an Associate Editor of *The Psychoanalytic Quarterly,* and former Editor of *The Psychoanalytic Quarterly.*

sis is supposed to address. In addition, therapeutic activity must be inferred from a study of the particular technical recommendations endorsed by a given approach to analytic practice.

To further complicate the problem, while modern conflict theory identifies itself as a direct evolutionary descendant of Freudian discoveries and postulates, in the current state of affairs, there exist a number of somewhat different versions of what was at one point referred to simply as *mainstream* or *classical* psychoanalytic theory. All these variations of the mainstream share a conviction about the central importance of instinctual conflict in human psychology, and, despite the differences among them, all these related lines of thought continue to prefer to be designated as part of the classical tradition, rather than as dissident offspring of it.

Perhaps the clearest way to approach the problem is to outline the historical development of this affiliated collection of theories, indicating along the way where important shifts of emphasis and divisions have appeared. At the outset, I must point out that, in assessing Freud's theories of therapeutic action—as well as those of the analysts whose subsequent work elaborated, amended, or challenged some of his ideas—it will prove useful to keep in mind an astute observation offered by Abrams in 1990. In his introduction to a panel on the topic of therapeutic action, he commented as follows: "Therapeutic action remained linked to a general theory of the mind, to specific theories of pathogenesis, to technique, and to a view of the treatment process" (p. 774). Of the factors mentioned here, surely a particular, explicit or implicit theory of pathogenesis is directly and inextricably associated with every theory of therapeutic action. In their turn, the relevant ideas about pathogenesis are invariably related to an associated general theory of the structure of the mind. In each case, a specific set of principles of technique and conceptions of the treatment process follow from the theory of therapeutic action to which they are linked.

## FREUD AND HIS GENERATION

We begin our historical survey, as usual, with Freud. Toward the end of his life, Freud (1937a) was still struggling to explain why analy-

sis is not effective in certain conditions, but he seemed completely confident that he understood how and why it works in the usual, favorable situation:

> Instead of an enquiry into how a cure by analysis comes about (*a matter which I think has been sufficiently elucidated*) the question should be asked of [sic] what are the obstacles that stand in the way of such a cure. [p. 221, italics added]

His confidence in regard to his theory of therapeutic action is all the more remarkable in view of the fact that he changed this theory in important respects several times over the course of his career.

Freud's protopsychoanalytic theory rested on the later-discarded mechanism of catharsis. Therapeutic effect was supposed to be achieved through the recovery, by means of focused speech, of traumatic memories that had been stored in a so-called hypnoid state—although he soon replaced this concept of a locus for the unavailable material with that of the unconscious. This early theory evolved into a far more sophisticated derivative during the first two decades of the twentieth century, with the topographic model of the mind forming the basis for Freud's ideas about mental structure and functioning. The emphasis on the recovery of sequestered unconscious material was retained, but the proposed mechanisms involved were now connected to Freud's newly acquired conviction that blocked or fixated libidinal wishes of childhood constitute the crux of that unconscious material. He concluded that repression, reinforced by other defenses, is the intrapsychic blockading element that resists the reemergence of these wishes into consciousness. This obstructing force must be overcome in order to allow the analysand's more mature, adult judgment to beneficially alter the fate of the libidinal drives.

Freud had learned by then that the transference relationships he had noticed and come to understand as being displaced from the past provide a stage upon which the repressed wishes are displayed, thus permitting their nature to be ascertained. Furthermore, he conjectured, the transference constitutes an opportunity

for the vivid, convincing, lively, and current reappearance of those important wishes, and thus facilitates the eventual reworking of them by means of the cumulative effect of the analyst's interpretations. The content of those interpretations was thought to provide the analysand with the necessary insight with which to effect changes.

The relationship to the analyst, in this schema, was assumed to supply two crucial ancillary functions. First, it makes up the background screen upon which transference distortions are displayed, and second, it provides a benign influence, the *unobjectionable positive transference* (Freud 1912), which motivates the patient to do the uncomfortable work of counteracting his or her resistances. In short, analysis of the transference helps to overcome resistances, undo repressions, and thus relieve pathogenic fixations.

As is familiar to students of psychoanalytic history, experience eventually led Freud to change his theory of neurosogenesis yet again, and thus also of therapeutic action, in a substantial way. For our purpose, it will suffice to note that the revision of anxiety theory, and the development of the structural hypothesis as a new working model of intrapsychic life, irrevocably altered the nature of therapeutic emphasis. Although Freud kept the idea of tension between forbidden unconscious libidinal wishes and the forces that restrict their access to consciousness as the cornerstone of his theory of neurosogenesis, the complex nature of these conflicts was more fully delineated.

The motives for repression were now conceptualized as a succession of fears, quite convincing to the child, involving parental disapproval and punishment, which in the course of development became internalized and subsumed under the influence of the moral agency known as the *superego,* itself active in a largely unconscious mode. The *ego* then emerged as the primary locus of therapeutic attention. Its multiple roles as initiator of defenses, executor of actions, evaluator of conditions in the environment, and synthesizer of conflicting elements in mental life placed the ego at the center of the analyst's interest, so much so that the next phase of Freudian psychoanalytic theorizing became known as *ego psychol-*

*ogy*. While divergent streams of psychoanalytic thought were already in evidence by the time this evolutionary trend made its appearance, and still other important currents would arise as time went on, our attention here will remain confined to tracing the further development of what came to be generally regarded as *mainstream* or *classical* Freudian psychoanalytic thought (Abend 2002a).

In his later elaborations of the theory of cure, Freud always held to his concentration on conflict—that is to say, the opposition between the resources of the ego and the pressure of instinctual forces seeking expression and satisfaction. His therapeutic interest increasingly centered on the modification of the capacities of the ego and on the consequent taming of the instinctual drives that might thereby be achieved. By the time he wrote "Constructions in Analysis" (1937b), he had come to appreciate that it was not always necessary for neurosogenic, repressed traumatic experiences to reemerge into conscious awareness since, "if the analysis is carried out correctly, we produce in . . . [the patient] an assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory" (pp. 265-266).

Thus, the fate of the instinctual wishes that had been subjected to distorting censorship in the course of childhood development remained at the center of Freud's theory of neurosogenesis. The idea that constitutional as well as experiential factors contribute to pathogenic development was always part of his theoretical substructure. Later, he came to believe that variations in the ability of the ego to deal with these powerful forces also contribute to the form and degree of psychopathology. Thus, both sides of the conflicts at the heart of pathology claimed attention in his evolving view of therapeutic action.

Except for the aforementioned value of what he designated as the unobjectionable positive transference as a motive force in propelling the treatment process, for the most part, Freud deemphasized the role of the analysand's relationship with the analyst in favor of a focus on the crucial role of acquired insight in empowering beneficial analytic changes. He explicitly disagreed with the suggestion that the analyst should adopt a role tailored to the treat-

ment of each analysand's specific neurosis, as was put forth by Ferenczi in his development of active technique. Freud also sought to counter the critical argument that the analyst's constructions and interpretations constitute no more than suggestions—which could quite possibly be altogether fallacious, yet could still influence patients to change.

However, it may be noted that Freud (1937a) was not entirely dismissive of the potential impact of the analyst's relationship to the patient in treatment, as witness his comment that "in certain analytic situations . . . [the analyst] can act as a model for his patient and in others as a teacher" (p. 248). Still, he did not elaborate these ideas about the function of the relationship, except perhaps insofar as he might have considered the analyst's formulation of constructions and presentation of interpretations as an educational activity. His emphasis became one of concentrating analytic efforts on modifying the analysand's ego so that it could better deal with instinctual demands. As he put it, "the business of the analysis is to secure the best possible psychological condition for the function of the ego; with that it has discharged its task" (Freud 1937a, p. 250).

By and large, Freud's contemporary followers merely attempted to further develop and elaborate an analytic understanding of the means by which the therapeutic alteration of ego capacities could be achieved. Thus, Sterba (1934) dealt with one conundrum by conceiving of the ego as divisible into experiencing and self-observing segments. Meanwhile, Strachey (1934), in concordance with his Kleinian orientation, outlined the suggestion that the analysand introjects the analyst's more benign superego as a pathway to transforming the anti-instinctual part of his or her psychic structure.

In the papers presented at the 1936 Marienbad symposium on therapeutic action, all participants held an absolute adherence to Freud's central conception of pathogenesis arising as a consequence of the conflict between instinctual wishes and the ego-superego system. What each contributor offered was one or another minor variation on the theme of how therapeutic strengthening of

the ego might be achieved (Bergler 1937; Bibring 1937; Fenichel 1937; Glover 1937; Nunberg 1937; Strachey 1937).

During this period, the publication of Anna Freud's book, *The Ego and the Mechanisms of Defense* (1937), and later of Otto Fenichel's *Problems of Psychoanalytic Technique* (1941), marked the evolution of ego psychology into a therapeutic approach that concentrates on the analysis of defenses. Fenichel's stress on analyzing from the surface was meant to support the shift of therapeutic technique away from the earlier tendency to interpret the presence of deep, unconscious, instinctual wishes that might be so far removed from conscious awareness, and so alien to patients' consciousness, as to be apprehended only intellectually, if at all. Thus, the theory of therapeutic action became crystallized as the systematic modification of the ego's capacity to deal with the persistent instinctual wishes of early childhood and to transform its function into one more appropriate to the circumstances of adult reality.

Despite the momentous introduction of the structural theory and its consequences for technique, analysts of the day and for many years thereafter continued at times to employ thinking derived from the topographic model, along with their adoption of the newer picture of how mental activity is organized.[1] Even Anna Freud was said to have admitted as much during discussions held at the Hampstead Clinic years after the 1937 publication of her seminal volume on defenses (Spruiell 1982).

One form this adherence to the topographic model took was the continuing interest in conceptualizing clinical phenomena in terms of levels of consciousness. (e.g., Stein 1965). Another was the persistence of Freud's interest in the idea of psychic energy and its postulated vicissitudes. Many analysts continued to be concerned with energic concepts dating from Freud's earliest theorizing. Hartmann (1939) elaborated on a brief comment of Freud's (1923) about the ego getting energy for its use from desexualized libido.

[1] It was not until 1964, when Arlow and Brenner published *Psychoanalytic Concepts and the Structural Theory*, that an argument stating definitively that the two models of mental functioning are logically incompatible was framed and presented.

Hartmann suggested that drive energies can exist in a tamed, or *neutralized,* state that is somehow different from the form that charges the instinctual component of neurotic symptoms. It is this kind of energy that Hartmann imagined could provide the required force for the ego tasks concerned with adaptation. A related innovation was his introduction of the notion of a "conflict-free" sphere of the ego. This theoretical leap was part of Hartmann's effort to expand the purview of psychoanalysis into that of a general psychology, rather than confining it to the realm of psychopathology.

## THE ELABORATION OF EGO PSYCHOLOGY

Hartmann and his two frequent collaborators, Kris and Loewenstein, who like him had emigrated from Europe to the United States in the wake of World War II, contributed to the further development of ego psychology during the decades of the 1940s and '50s. As important as their influence was, the significance of their work for the theory of therapeutic action was far from radical, consisting mostly of small refinements. Kris (1956), for example, noted that other transference attitudes besides Freud's celebrated unobjectionable positive transference can serve as a motive for certain analysands' acquisition of insight, thus making analytic progress possible.

Most analysts of that period sought to preserve the Freudian legacy and did not change the fundamental assumptions about pathogenesis, and hence about therapeutic action, that they had inherited. To be sure, clinical experience by that time demanded that more explicit attention be paid to aggression and its role in conflict, and therefore to an expanded picture of what constitutes psychopathology and its alleviation. Other analysts who were interested in child development also broadened the frame of analytic conceptualization without at first changing the terms of a theory of treatment. They concentrated on specifying a fuller elaboration of preoedipal events and issues, both in terms of normal development and of pathogenic derailments and their consequences. This work affected the focus of analytic interest and hence the content

of interpretations, but not necessarily the overview of therapeutic action. In the debates of the times, it was possible for one contributor, Gill (1954), to suggest a definition of psychoanalysis that included only the long-familiar elements of instinctual conflict that become clinically manifest in the transference neurosis, and that were to be cured through the resolution of the latter, "by means of interpretation [and hence of insight] . . . alone" (p. 775).

At mid-century, then, the Freudian psychoanalytic mainstream held to a certain set of shared beliefs. Among them were: (1) that neurotic symptoms are the consequence of the ego's conflictually determined, partially successful, warding off of the full and free expression of certain instinctual wishes of childhood origin; (2) that this symptom picture is embedded in an otherwise healthy personality (although uncertainty was already in evidence about how to understand and classify certain types of character development); (3) that, in analysis, these troublesome instinctual conflicts appear as a complex set of attitudes toward the analyst, known by the collective term *transference neurosis;* (4) that this formation can be observed and understood by the neutral, objective analyst; (5) that the analyst interprets to the analysand the constituent parts of the transference neurosis, as well as the reconstructed childhood antecedents that determine its shape; (6) that the analyst deliberately avoids trying to influence the patient to change in any other way besides offering clarifying interpretations; and, finally, (7) that in successful cases, the patient's transference neurosis is "resolved," and he or she is thereby restored to health. Other contending points of view, such as those of the interpersonal school and the Kleinian movement, were already well developed by that time, but the foregoing tenets constituted the core principles of Freudian ego psychology.

## THE EMERGENCE OF THEORETICAL VARIABILITY

It is probably fair to call this period the high-water mark of theoretical orthodoxy, because the winds of change were already in evi-

dence and their effects would soon be discernible. Among the most important influences that would slowly move theory away from its faithful adherence to Freud's ideas, at least three took center stage during the 1960s. The first of these factors was the reconceptualization of the part played by countertransference in the psychoanalytic encounter. Introduced and elaborated by Kleinian analysts in the preceding decade, the suggested utilization of the analyst's self-observation of his or her own feeling states while with each patient, as an important tool for learning about the analysand's psychic activity in the analytic situation, was hotly contested for many years by mainstream Freudians. Although some of the latter held out for quite a long time, this particular theoretical resistance was to prove a losing battle.

A second major shift was the upsurge of interest in the nature of preoedipal development and its determinative influence on neurosogenesis and on character formation. This work, following the contributions of pioneers like Winnicott (1971) and Mahler (1965), among others, was gradually incorporated into the study of the limitations of ego capacities in certain analysands, especially those suffering from more serious forms of psychopathology.

Finally, other mainstream students of the complexities of the psychoanalytic situation, like Greenson (1967), Modell (1984), Stone (1961), and Zetzel (1970), developed the idea that realistic aspects of the relationship between the analysand and the analyst exist alongside, and are distinguishable from, the transference neurosis. This dimension of their relationship was presumed to constitute a form of alliance, called by various names, which was comparable to but more complex than Freud's idea of the unobjectionable positive transference. The alliance supposedly provides an essential substructure, which permits interpretive work on the transference distortions to be effectively performed. Especially with more difficult, disturbed analytic patients, some analysts suggested, the analyst must take steps to facilitate and strengthen the alliance as part of the therapeutic task of analyzing.

In the context of these developments, Loewald (1960) introduced an emendation to the theory of therapeutic action that was

to prove crucial to the next generation of analytic theorists. He presented the idea that the analyst is much more than simply a detective, or an archeologist of the mind, whose work consists only of the discovery of the residues of a pathogenic buried past, followed by the disclosure of these fragments to the conscious awareness of the patient. Instead, Loewald compared the analyst's task to that of the mother of a developing child, emphasizing that a vital aspect of it is to articulate inchoate aspects of the analysand's unconscious mind, thus helping to shape and define his or her desires, capacities, and, ultimately, capabilities. In short, the analytic interaction does more than discover hidden meanings, according to Loewald; it actually helps to create new meanings in the mental life of the analysand.

The impact of this important new step in the evolution of the theory of therapeutic action was soon to be reinforced by certain derivatives of postmodern intellectual trends that a number of psychoanalytic thinkers found persuasive. The assault on positivism, as far as psychoanalysis is concerned, was used to mount a challenge to the comfortable assumption that the analyst is a scientific observer capable of arriving at reliable, objective judgments about the nature of reality and about the patient's psychic structure.

This attack on one of the foundation stones of what had been, up to then, prevailing psychoanalytic doctrine and practice soon became a focus of controversy. The development of a frankly relativist or subjectivist trend, characterized by the elaboration of the idea that all meaning is established only by the co-construction of the analyst and analysand working in tandem, would be taken up most enthusiastically by analysts who belonged to analytic schools of thought that were no longer part of mainstream Freudian conflict theory. However, it was becoming more and more difficult to determine which lines of thought constituted variations on the evolving Freudian mainstream, and which preferred to be regarded as separate, independent schools of psychoanalytic theory and practice.

## RECENT DEVELOPMENTS IN THE THEORY OF THERAPEUTIC ACTION

In psychoanalytic circles within the United States, it is certainly possible to distinguish several divergent versions of the theory of therapeutic action that emerged in the last quarter of the twentieth century, all of which would still be considered part of the mainstream directly derived from classical Freudian theory. The most fundamental aspect of the new complexity is probably the stress placed upon conceptualizing the role of the relationship between analyst and analysand as a prime determinant of therapeutic action. As I have indicated in tracing the history of this issue, balancing the effects of the relationship and the power of insight in bringing about therapeutic change had long been an active center of debate in psychoanalysis, especially between the strictest of Freudian loyalists and the proponents of other schools of analytic thought. However, over the course of time, many analysts who still regarded themselves as part of the traditional mainstream sought to incorporate some way of more thoroughly understanding how the relationship might play a role in analysis, in addition to the long-familiar idea that it constitutes a neutral platform upon which insight into the patient's conflicts can be formulated, communicated, and ultimately assimilated.

Before outlining these developing variants of the theory of therapeutic action, I would like to point out that there is still an important segment of the mainstream psychoanalytic community that believes the traditional Freudian emphasis on the detection and interpretation of the derivatives of conflict, which facilitates the analysand's cumulative acquisition of insight into his or her nature and history, remains the most important tool for bringing about therapeutic results. In the view of these analysts, this work is supported by the long-familiar precepts of studying emerging transference patterns, and, at least in some cases, by the recovery of important memories, as well as through the analytic reconstruction of the past. The sizeable number of analysts who adhere to this model of technique and therapeutic action, of whom I am one,

respect the power of the relationship between analyst and analysand as contributing to therapeutic outcome, but harbor a certain degree of skepticism about some of the formulations concerning how this factor might have an effect on altering psychopathology.

In addition, for many of us, the current emphasis on the inevitably subjective limitations of the analyst is primarily useful as a caution to analysts about placing excessive confidence in the intuitive accuracy of their evaluations of patients' mental functioning and their understanding of the meaning of patients' productions. It implicitly serves as a reminder that careful attention to patients' responses, together with respectful consideration of their views of what transpires in analysis, is necessary in order to arrive at reliable interpretations of the analytic data.

However, in our view, acknowledging that the analyst unavoidably labors under the burden of certain personal constrictions, predilections, and imperfections does not completely abolish the analyst's decidedly advantageous position in the analytic situation. By virtue of training, personal analysis, and experience, analysts are able to perceive and understand things about their patients that the latter cannot see, and that—as has been appreciated since the time of Freud—analysands are motivated *not* to understand or accept as part of themselves. Therefore, the activity of interpretation, despite contemporary appreciation of the analyst's subjective limitations, nevertheless remains central to the performance of the analyst's task. Other differences among subsets of traditional analysts may become clearer in the descriptions to follow.

For example, derived from the contributions of such thinkers as Winnicott (1971) and Modell (1984), the idea gained in appeal among one large segment of analysts that the relationship that develops between the analyst and the analysand may have certain corrective features that can be incorporated into the psychic structure of patients who are burdened by faulty object relatedness, even if these changes are never explicitly discussed by the analytic pair. This subtle variant of the corrective emotional experience, in some hands at least, has also called for the analyst to behave in ways that are different from the classically prescribed technique of

strict analytic neutrality. It was proposed that behaving in a less formally analytic fashion, and being more declaratively realistic and demonstrably reasonable, predictable, and caring in interactions with patients, particularly sicker ones, has a cumulative effect on their capacities for relatedness. While this change in the analyst's technique can be thought of as consistent with the Freudian analytic goal of beneficially altering ego capabilities, it represents a significant departure from the view that such changes should be brought about through interpretation and insight alone. A background assumption of those who have supported this prescription for strengthening the patient's ego has been that the difficulties they hoped to overcome were an experiential consequence of specific, preoedipal developmental problems. It is precisely this latter assumption about development and the nature of psychopathology that many other mainstream analysts have found less than convincing.

The student of mainstream analytic theory can observe a spectrum of opinion about the importance of the relationship as a therapeutic influence. Conservative voices, such as that of Stone (1961), emphasized the reality-based core of the therapeutic alliance as needed to support analytic work with all patients, but not necessarily as designed to modify faulty development. Other analysts, like Greenson (1967) and Zetzel (1970), were more openly in favor of modifying the analyst's behavior with patients—away from the restrictive model advocated by some followers of Freud, and into a way of relating aimed at helping patients respond to the demands of analysis. The crystallization of these approaches into one in which the relationship, as experienced by the analysand, slowly alters his or her developmental limitations, irrespective of interpretation, has gradually invaded mainstream thinking in many quarters, even though its most enthusiastic advocates came from other schools of analytic thought.

More or less independent of this newly emergent stress on the role of the relationship in therapeutic action, there has been a growing interest in studying the vicissitudes of the relationship in the transference-countertransference matrix. The Kleinian focus

on using the analyst's countertransference reactions as a tool with which to better understand the patient began to be incorporated into the work of a growing number of mainstream analysts who nevertheless did not subscribe to Kleinian metapsychology or its stress on projection-introjection mechanisms. Sandler's (1976) idea of role responsiveness, Jacobs's (1991) work on acute observation of the analyst's subtle nonverbal countertransference enactments, and Boesky's (1990) interest in understanding the co-creation of resistances are examples of this trend.

In all versions of this technical development, it has been recommended that the analyst attempt to examine closely the specific nature of certain of his or her interactions with analysands. Beginning by noting the manifest qualities of these interactions, analysts should then apply the usual effort to understand their subtle unconscious significance. Acknowledging that the analyst is an unwitting (i.e., unconscious) participant in these interactions, these theorists insist that the analyst's at least intermittently mobilized ability to step back from, observe, and make analytic sense of the interactions constitutes an important step in the formulation of many interpretations to analysands.

While this change of focus affects the form of therapeutic technique, it is not necessarily true that it should be thought of as significantly modifying the theory of therapeutic action. Insight is still regarded as the essential element in bringing about change, and the study of the transference-countertransference relationship becomes an additional vehicle with which an understanding of the patient's mental activity—leading to interpretation, and thus to insight—is to be achieved.

Other evolutionary trendsetters in the mainstream current were far less enthusiastic about the tendency to promote the idea that the relationship might be an ameliorative influence in analytic treatment. Especially notable in this regard is the work of Arlow and Brenner (1964, 1990). Without holding to an illusion of the analyst's possessing perfect objectivity, they maintained their belief that usefully accurate assessments are possible, especially if scrupulous care is taken to examine the evidence provided by the ap-

pearance of prominent patterns and recurring sequences in the patient's verbal productions and behavior. They thus advocated maintaining analytic focus on the problem of detecting and interpreting signs of the components of patients' unconscious conflicts by a careful study of the analytic material, including, but not confined to, the transference.

Arlow (1969), in particular, emphasized looking for the presence and mode of expression of crucial unconscious fantasies that incorporate the elements of conflict. He also devoted attention to the nuances of constructing interpretations and to describing the nature of analytic evidence. Brenner (1979) challenged the idea of a therapeutic alliance as reliably distinguishable from transference, and he regarded variations of standard analytic behavior that were supposedly designed specifically to strengthen the alliance as actually liable to constitute invitations to subtle enactments, whose unconscious meaning might escape full analytic scrutiny.

Brenner also developed and promulgated the formulation that the outcome of instinctual conflicts can best be described as a set of compromise formations, although he used that term to designate a more comprehensive complexity than was implied in Freud's much earlier employment of it to describe symptom formation. According to Brenner (1976), compromise formations are composed of (1) specific libidinal and aggressive wishes, (2) an associated dysphoric affect, (3) moral concerns, couched in terms of potential punishments, and (4) a variety of ego functions arrayed defensively and seeking an acceptable, adaptive balance among these forces. Brenner has suggested that the familiar conception of the id, ego, and superego as agencies of the mind, the cornerstones of structural theory, is no longer an accurate or useful way of accounting for the mental activities that are of interest to psychoanalysts. He prefers to focus simply on the elements that constitute the varieties of intrapsychic conflict and their interaction in compromise formations as clinical phenomena, without reference to structural entities.

Brenner is one of the analysts who assert that the proof of any theory of therapeutic action cannot be demonstrated. Instead, it is

only possible to observe and describe certain changes that accompany improved functioning in patients. In Brenner's preferred formulation, these changes consist of the substitution of new compromise formations, ones that permit more gratification and entail less dysphoria and/or self-punitive behavior, for the more pathological ones they replace. His understanding of how these changes are brought about remains centered on the patient's gradual acquisition of meaningful insight.

However, Brenner and many other proponents of modern conflict theory, myself included, acknowledge that the way in which analysands experience their relationships with their analysts is meaningful and influential in bringing about change. The analyst is, after all, a person who responds to the patient's transference demands and behavior differently from the way that all other figures of importance in the patient's life have, and this must carry a significant cumulative impact. In our opinion, though, how this influence is to be incorporated into a theory of therapeutic action remains a matter of speculation and is subject to debate. A sharp division exists between those analysts who are convinced that relational distortions resulting from early, even preverbal developmental difficulties can be correctively influenced by the very nature of the new relationship that forms between patient and analyst, and those who question this fundamental premise. As one of the latter group, I see this relational emphasis as consistent with the long-standing historical trend to deemphasize the central importance to analysis of sexual and aggressive conflicts in favor of increased attention to preoedipal developmental issues. To some analysts, including many in the expanded mainstream, this shift is an advantageous advance in analytic understanding, while others of us still hold to Freud's revolutionary focus on the complex consequences of the oedipal period on both normal and pathological human psychological development.

Another, newer trend in the mainstream that presents still a different variation of therapeutic action derives from the work of Gray (1994) and those influenced by his ideas. He developed a unique technical stance known as *close process monitoring,* in which

the analyst attends exclusively to the flow of verbal material produced by the patient during the analytic hour. This approach goes beyond the widely agreed upon technical principle of noting hesitations, breaks in continuity, and sudden shifts of focus in the patient's productions as of importance, since they indicate that defensive influence is at work on the flow of associations. Gray proposed that even if the patient presents dynamically interesting and significant material, such as dreams or accounts of meaningful past or current incidents, this should be examined as having possible defensive valence, depending on context. His view was that the analysand has conscious or unconscious anxiety at the prospect of verbally revealing certain charged mental contents in the presence of the analyst, and that this discomfort may initiate seductively interesting changes of subject matter, which the analyst who follows conventional technical wisdom might tend to regard as valuable to examine for its content alone.

Gray advocates, instead, a strict attention to the defensive function of such material, in addition to noting the more usual indicators of defense at work. This exclusive focus on defense analysis, with the transference emphasis of concern for the analyst's possible judgmental reactions, becomes the centerpiece of analytic work with those patients who are capable of sustaining it.

Gray also formulates a subsidiary goal of educating the patient over the course of the analysis to be able to execute a similar kind of detailed scrutiny for him- or herself, without the aid—or, ultimately, even the presence—of the analyst. Therapeutic benefit from this procedure is assumed to be a function of the analysand's gradual acquisition of an enhanced freedom to admit to consciousness thoughts linked to desires or emotional attitudes that had previously been regarded as dangerously unacceptable. Other, more limited patients might require a technique in which the role of the analyst's suggestion, approval, or disapproval continues to contribute to therapeutic effectiveness, according to Gray.

Besides the factors outlined in all general theories of therapeutic action derived from specific sets of ideas about the structure of psychopathological formations and how they are revised, there may

also be features of analysands' individual psychology, unique to each case, that can influence therapeutic outcome (Abend 2002b). I have in mind the presence of unconscious fantasies about treatment, cure, change, and about being influenced by others, which are important aspects of the psychological makeup of certain analysands. While such fantasies invariably originate in earlier formative relationships, they can play a transferential role of great but subtle significance in determining how a particular analysand responds to analysis, either promoting change or, in other cases, resisting it. It is not necessary to incorporate such potential responsiveness into a general theory of therapeutic action, but it is important to recognize that this kind of influence may strongly affect therapeutic effectiveness, for better or for worse. From the standpoint of technique, it is necessary only that the analyst remain aware of this possibility, since dedication to the usual analytic task of sensing, understanding, and interpreting such transference fantasies and their infantile antecedents is all the analyst can do to modulate their potential influence.

## SUMMARY AND CONCLUSIONS

Theories of therapeutic action are all connected to specific sets of beliefs about how the mind is structured, and in particular about the assumed composition of the psychopathological formations they are intended to relieve. In modern conflict theory, just as in Freud's conceptualization, the essence of the difficulties psychoanalysis seeks to address is intrapsychic conflict of childhood origin. This refers to the inherent tension between certain unconscious instinctual wishes that strive for gratification, and the developing child's anxiety-fueled, defensive need to conceal, modify, or modulate those wishes. These defensive efforts try to permit a degree of satisfaction while also avoiding the anticipated dangers that the immature child is convinced are associated with the direct expression of such instinctual wishes.

Brenner's detailed description of these conflicts as leading to compromise formations seems to me a useful, accurate, and eco-

nomical way of formulating these issues in psychoanalytic terms. It follows from this conceptualization that the therapeutic activity of psychoanalysis is, at bottom, an effort to alter the composition of certain compromise formations that account for symptoms or disadvantageous aspects of character, in favor of new compromise formations that afford more satisfaction of wishes and entail a lesser degree, if not a total relief, of the associated discomfort.

A great advantage of this way of thinking about the aims and actions of psychoanalysis is that it addresses one particular conceptual legacy of early Freudian theory that has outlived its usefulness. When Freud began his career, his model for the neurotic disturbances he sought to alleviate was based on that of conventional medical diseases, like infectious illnesses. Accordingly, he sought to identify pathogenic agents, and to remove them in order to cure the patient's symptoms. When he learned that repressed traumatic memories did not account for all psychopathology, and replaced that idea with the concept that certain residual consequences of childhood instinctual conflicts lie at the heart of the problems psychoanalysis tries to address, he did not discard the fundamental assumption that these emotional pathogens are to be removed in order to restore the patient to complete health.

Even much later in his career, when Freud had come to regard etiology in a more complex way, and to view outcome less categorically and less optimistically, he never troubled to revise the implications of his earlier formulation. Consequently, he and his followers carried over a more sophisticated version of his earlier disease template in the form of conceiving of the goal of the analysis as the "resolution" of the transference neurosis, with the implication that the full achievement of this aim is possible, long after accumulated clinical experience suggested that this is an inaccurate idealization.

Brenner's formulation requires analysts to acknowledge that instinctual conflict is never completely abolished; it remains a permanent and ubiquitous feature of human mental life. What is possible is to effect changes in the consequences of conflict, and hence in the manifestations that are the expressions of the com-

promise formations involved. To be sure, symptoms may be abolished, character traits altered in a profoundly beneficial way, object relationships improved, adaptations to reality significantly changed in the direction of consensual normality, and so on. Such important changes and other benefits of a successful analysis are in no way minimized by acknowledging that they result from changes in the way childhood instinctual conflicts are handled, and not by their complete elimination or resolution.

Among the several currents that may be considered part of present-day, mainstream, conflict-centered Freudian psychoanalysis, there is an evident consensus that therapeutic activity is attributable to two chief categories of agents of influence. The first of these, which dates back to Freud's original thesis, is that of *insight*. In short, psychoanalytic therapy is designed to result in an expansion of the analysand's conscious knowledge of certain crucial, previously unrecognized and unacknowledged aspects of his or her unconscious mental life. In essence, this increased self-understanding includes an appreciation of the continuing presence and importance of a variety of libidinal and aggressive desires, and a fuller understanding of the different ways that the person devised during childhood in order to deflect, alter, disguise, and also gratify those wishes. To make this self-knowledge more comprehensible, the analysand must also come to understand the real and imaginary dangers that he or she has associated with the expression, or even the revelation, of these wishes, as well as something of the real and imagined experiences of childhood that contributed to the development of the patient's particular set of compromise formations.

Insight may be generated by the analyst's interpretations, by the patient's self-discoveries, or both, but it is now widely agreed that this insight must be emotionally convincing to the patient, not merely intellectually apprehended. Experiences of the components of a patient's conflicts in the immediacy of the transference relationship are considered an essential part of the acquisition of truly meaningful insight. It should be noted that there are different assumptions about the precise content of the ideational com-

ponents of these compromise formations within the mainstream psychoanalytic community, but these differences do not change the fundamental conception of conflict or the presumed therapeutic value of acquiring insight into its nature and origin.

The second broad category of therapeutic influence is subsumed under the general heading of the analysand's experience of his or her relationship with the analyst. No analyst today would deny that the lengthy, intense, emotionally charged involvement between the two participants in an analysis has a profound and lasting impact on the psychology of the analysand (and, to a lesser degree, on that of the analyst, for that matter). Likewise, none would disagree that this relationship is a unique experience for the analysand, since the analyst consistently strives to be helpful in a particular way and to respond to the patient's emotional needs, demands, and reactions in a fashion different from that of all others in the analysand's past and current emotional world. Furthermore, it is generally acknowledged that the analyst's emotional attunement to his or her own mental states and behavior during the conduct of the treatment can sometimes be a valuable source of data about the patient's mental activities. Beyond those generalizations, there lies a considerable difference of opinion among various subgroups of mainstream analysts about how to assess the therapeutic influence of the relationship.

Some rely much more than do others on the utilization of countertransference scrutiny as a tool for understanding the patient and formulating interpretations. Some even attribute so much importance to transference-countertransference interactions as to include this dimension of the analytic work in their basic formulation of the therapeutic process. Because I am one of those analysts who harbor significant reservations about what appears to me to be in some hands an overly optimistic attitude about the reliability of this kind of data, I personally lean quite heavily in the direction of caution about its employment. I also join those who call for making every effort to verify any formulation about the patient. This is most reliably done by carefully scrutinizing the patient's behavior patterns and the contents of the patient's verbal

productions for evidence to support, modify, or invalidate formulations based on countertransference data.

As for the corrective influence that the relationship exerts on the psychological makeup of the analysand, the range of opinions among mainstream psychoanalysts is a substantial one. As I have indicated in the preceding historical survey, there are those who are convinced that the relationship has a beneficial effect on the analysand's capacity for object relations, all the more important in those cases where problems in that sphere are seen to be a major factor in the patient's psychopathology. Emphasis on the presumed pathogenic significance of preoedipal developmental disturbances is likely to be part of the rationale of those analysts who place great stress on the therapeutically important impact of the relationship, especially on its nonverbal (perhaps even nonverbalizable) components.

There are also a number of analysts who hold to the view that the realistic relationship between analyst and patient is a core feature of analytic work, constituting a kind of alliance between the participants that supports and sustains the analysand's ability to experience and effectively analyze transference distortions. A certain percentage of this subgroup of mainstream analysts also advocates that the analyst behave in a fashion at variance with the restricted range of technical behavior recommended by Freud and many subsequent practitioners. These prescriptions vary from the adoption of specific attitudes and attributes designed to address particular problems, to the less extreme suggestion that a more "natural" and "realistic" mode of conducting the relationship has the effect of strengthening the alliance. As noted, there are other analysts, of whom I am one (see Abend 2002b), who regard such proposals as less valid and less analytically benign and useful than do their proponents.

Finally, it is potentially helpful to keep in mind that individual analysands may have significant unconscious fantasies, derivatives of which are active in the transference, that can have a positive or a negative impact on the patient's responsiveness to analytic influence. For example, certain cases where transference fantasies that

determine a patient's reluctance to acknowledge the analyst's power to be helpful, or which support a resistance to accept change, are probably familiar to most practitioners. Transference fantasies that may serve to support accommodative growth and change may be less obvious, but are no less important to take into account.

In sum, there is much about the therapeutic action of psychoanalysis, and of the technical procedures that are best suited to achieve a favorable therapeutic result, that is uncertain and/or in dispute. The different configurations are connected to and derived from particular views of the mind, how it develops and functions, and of the structure of the disturbances analysis attempts to relieve. Modern conflict theory, like all other approaches, sets forth its ideas about therapeutic action in a fashion consistent with its assumptions about this greater context.

This cautionary note should not be taken to imply skepticism about analytic effectiveness. As we conduct our work, we are able to observe and describe undeniably beneficial changes in many analysands' mental functioning and in the way they carry out and experience their lives. In view of this, it seems entirely justified to attribute therapeutic action to our analytic endeavors. It is simply a fact that each of us is obliged to organize our observations and descriptions, and the theories of treatment to which they are connected, in the conceptual language of our particular preferred version of psychoanalytic theory. We continue to practice in accordance with our conviction that these endeavors provide a unique opportunity to help our patients attain the therapeutic gains that analysis can offer.

## REFERENCES

Abend, S. (2002a). In retrospect: reflections on a psychoanalytic career. *Psychoanal. Inquiry*, 22:43-54.

——— (2002b). Factors influencing change in patients in psychoanalytic treatment. *J. Clin. Psychoanal.,* 11:209-223.

Abrams, S. & Welsh, H. (1990). The nature of the therapeutic action of psychoanalysis: how analysis works. *J. Amer. Psychoanal. Assn.,* 38:773-788.

Arlow, J. (1969). Unconscious fantasy and disturbances of conscious experience. *Psychoanal. Q.*, 38:1-27.

ARLOW, J. & BRENNER, C. (1964). *Psychoanalytic Concepts and the Structural Theory.* New York: Int. Univ. Press.

——— (1990). The psychoanalytic process. *Psychoanal. Q.*, 59:678-692.

BERGLER, E. (1937). Theory of the therapeutic results of psychoanalysis—symposium. *Int. J. Psychoanal.*, 18:146-160.

BIBRING, E. (1937). Theory of the therapeutic results of psychoanalysis—symposium. *Int. J. Psychoanal.,* 18:170-189.

BOESKY, D. (1990). The psychoanalytic process and its components. *Psychoanal. Q.*, 54:550-584.

BRENNER, C. (1976). *Psychoanalytic Technique and Psychic Conflict.* New York: Int. Univ. Press.

——— (1979). Working alliance, therapeutic alliance, and transference. *J. Amer. Psychoanal. Assn.,* 27(suppl.):137-157.

FENICHEL, O. (1937). Theory of the therapeutic results of psychoanalysis—symposium. *Int. J. Psychoanal.*, 18:133-138.

——— (1941). *Problems of Psychoanalytic Technique.* New York: The Psychoanalytic Quarterly.

FREUD, A. (1937). *The Ego and the Mechanisms of Defense.* Madison, CT: Int. Univ. Press.

FREUD, S. (1912). The dynamics of transference. *S. E.,* 12.

——— (1923). *The Ego and the Id. S. E.*, 19.

——— (1937a). Analysis terminable and interminable. *S. E.*, 23.

——— (1937b). Constructions in analysis. *S. E.*, 23.

GILL, M. (1954). Psychoanalysis and exploratory psychotherapy. *J. Amer. Psychoanal. Assn.,* 2:771-797.

GLOVER, E. (1937). Theory of the therapeutic results of psychoanalysis—symposium. *Int. J. Psychoanal.*, 18:125-132.

GRAY, P. (1994). *The Ego and the Analysis of Defense.* Northvale, NJ: Aronson.

GREENSON, R. (1967). *The Technique and Practice of Psychoanalysis.* New York: Int. Univ. Press.

HARTMANN, H. (1939). *Ego Psychology and the Problem of Adaptation.* New York: Int. Univ. Press.

JACOBS, T. (1991). *The Use of the Self.* Madison, CT: Int. Univ. Press.

KRIS, E. (1956). On some vicissitudes of insight in psycho-analysis. *Int. J. Psychoanal,* 37:445-455.

LOEWALD, H. (1960). On the therapeutic action of psychoanalysis. *Int. J. Psychoanal.,* 41:16-33.

MAHLER, M. (1965). On the significance of the normal separation-individuation phase, with reference to research in symbiotic child psychosis. In *Drives, Affects, Behavior, Vol. 2*, ed. M. Schur. New York: Int. Univ. Press, 2:161-169.

MODELL, A. (1984). *Psychoanalysis in a New Context.* New York: Int. Univ. Press.

NUNBERG, H. (1937). Theory of the therapeutic results of psychoanalysis—symposium. *Int. J. Psychoanal.*, 18:161-169.
SANDLER, J. (1976). Countertransference and role-responsiveness. *Int. Rev. Psychoanal.,* 3:43-48.
SPRUIELL, V. (1982). Personal communication.
STEIN, M. (1965). States of consciousness in the analytic situation. In *Drives, Affects, Behavior, Vol. 2*, ed. M. Schur. New York: Int. Univ. Press.
STERBA, R. (1934). The fate of the ego in analytic therapy. *Int. J. Psychoanal.,* 15:117-126.
STONE, M. (1961). *The Psychoanalytic Situation: An Examination of Its Development and Essential Nature.* New York: Int. Univ. Press.
STRACHEY, J. (1934). The nature of the therapeutic action of psycho-analysis. *Int. J. Psychoanal.,* 15:127-159.
——— (1937). Theory of the therapeutic results of psychoanalysis—symposium. *Int. J. Psychoanal.*, 18:139-145.
WINNICOTT, D. W. (1971). *Playing and Reality.* New York: Routledge.
ZETZEL, E. (1970). *The Capacity for Emotional Growth.* New York: Int. Univ. Press.

---

*245 East 87th Street*
*Apartment 17G*
*New York, NY 10128*

*e-mail: sabend@cyberpsych.org*

*Psychoanalytic Quarterly, LXXVI, 2007*

# ON THERAPEUTIC ACTION

BY MARILIA AISENSTEIN

*The author presents her views on therapeutic action in the light of an examination of key Freudian works. She also discusses the work of some psychoanalytic thinkers who followed Freud, such as Klein and Green. Lacan's thinking and his influence on French psychoanalysis are summarized. A detailed clinical vignette is presented to illustrate the author's use of the psychoanalytic method to ameliorate a patient's troubled mental functioning.*

The notion of therapeutic action does not belong to the concepts that constitute Freudian metapsychology. Freud himself rarely discussed it, although it underlies the entirety of his work. Freud was convinced of the therapeutic effectiveness of psychoanalysis. It is true that his contact with patients suffering from hysteria led him to examine the question of its effectiveness, but he never lost his conviction. In fact, he always sought to sharpen and even alter his theory in the face of disappointing clinical results.

The discoveries of the negative therapeutic reaction, traumatic neurosis, and the compulsion to repeat thus led him to introduce the concept of narcissism into his theory of the drives (Freud 1914a), and then to abandon the first drive dualism—the drives of self-preservation and the sexual drives—and to replace it with the opposition between the libido and the death drive (Freud 1920).

---

Translation by Steven Jaron.

Marilia Aisenstein is a Training Analyst of the Paris Psychoanalytical Society and the Hellenic Psychoanalytical Society.

Likewise, the second drive theory brought him to revise how he had conceived the first topography of the psychic apparatus, suggested in chapter seven of *The Interpretation of Dreams* (1900), in which three systems—the unconscious, preconscious, and conscious—are differentiated. Each system has its own function, process, and energy, and each is distinguished by its representative content. Between them Freud places censors that inhibit or control the passage from one to the other. The central thesis of the distinction between the systems is related to the dynamic conception essential to all psychoanalytic thought, in which the systems are in conflict with one another.

From 1920 on, the opposition between the death drive and the libido, the latter of which combines sexuality and self-preservation —worked out, in my opinion, in order to take into account human destructiveness, whose stakes and unconscious defenses he had not initially assessed—forced Freud to rethink his understanding of the topography. In fact, here, too, failures in his clinical practice made him see that it was not always possible to make the poles of the defensive conflict coincide with his systems—that is to say, the repressed coincide with the unconscious, and the ego with the preconscious-conscious.

More complex than the first topography, the second topography brings into play three agencies: the id, or the drive pole of the personality; the ego, or the agency that represents the interests of the entirety of the person, by definition invested by the narcissistic libido; and, finally, the superego, which is made up of internalized demands and parental prohibitions. This conception permits not only the frontiers of one system to be brought into play, but also the relations within a system and between systems.

As one can see, the first topographical conception is truly *topographical* because it is spatial, whereas the second seems to me to be marked more by the notion of a *scene,* as in the scene of a dream or fantasy, the intrasubjective field being modeled on the intersubjective conception. Freud never gave up trying to reconcile the two topographies; thus, in chapter six of *An Outline of Psycho-Analysis* (1938), he again attempted to give a spatially figured depiction of

the whole of the psychic apparatus, in which the divisions between the conscious, unconscious, and preconscious coexisted like the divisions and relations between the ego, id, and superego.

I remain a passionate reader of Freud's works, which strike me as having thousands of openings. I constantly return to them, just as I do to a dictionary in which one entry inevitably sends me off to examine several others. I picture Freud's works as a gigantic puzzle in which the discovery that one small piece is missing leads to the reconstruction of the whole, but in accordance with rules that oblige me to retain everything while nevertheless altering it. At times, I associate this metaphor with the kaleidoscope that fascinated me during my childhood; shaking it changed the image, and another was formed out of the same pieces.

And yet there is a profound historical dimension to Freud's works, in addition to variables or principles that he never abandons. These principles guided him in a relentless investigation that underpinned his theoretical rigor. Here is a non-exhaustive list of five Freudian principles, all of which are obviously correlative:

1. The unconscious.
2. The drive, whose source is somatic; it delegates its representatives in the psyche and is always opposed to other drives.
3. The duality of drives.
4. Conscious or unconscious psychic conflict, constitutive of human beings—between desire and defense, between drives, and between agencies—whose first instance is the oedipal conflict.
5. And the last among these axes seems rightly to be a conviction about therapeutic action in psychoanalysis.

Freud reasserts this conviction in the final lines of the thirty-fourth lecture ("Explanations, Applications and Orientations"), written in 1933. There he insists on the *truth* value of psychoanalysis. For him, this truth makes improvement possible. He follows this with the statement that

> As a method of treatment it is one among many, though, to be sure, *primus inter pares*. If it was without therapeutic value it would not have been discovered, as it was, in connection with sick people and would not have gone on developing for more than thirty years. [1933, p. 157]

Seventy years later, this second sentence still has a burning timeliness. The question remains of how best to define what we mean by the effects of therapeutic action. In my view, this principle evolved during the course of Freud's works, and it sometimes remains a source of ambiguity since it is closely correlated to our understanding of the psychic apparatus and how it functions—just as it is to cultural and personal conceptions (sometimes implicit ones) of human beings and the world.

I will return presently to the issue of differences in our implicit or explicit theories in order to try to understand how these can be compared within the psychoanalytic field, and how they reveal themselves in the way we make clinical interpretations. But before doing so, I would first like to discuss the evolution of the notion of therapeutic action in Freud's thought, in which I see several stages. According to the classical medical model, the effect of a therapeutic action, whatever it is, may be summed up as a recovery from the symptom and as a "return *ad integrum*." In psychoanalysis, this model very quickly proves hardly tenable, however. Sedating even a neurotic symptom does not imply a return to a prior state, but rather a psychic modification connected to the patient's having brought to consciousness what had been repressed. Change replaces the idea of mere catharsis.

If, for Freud, the model of psychoanalysis as a therapy is born out of the idea of the removal of the conversion symptom, then this model will go on to become increasingly complex. In the cure, the idea of a psychic working through (*Durcharbeiten*) replaces the working out of resistances. Psychic working through should first be understood in reference to the Freudian concept of the psychic apparatus, which transforms and transmits the drive's energy, itself defined from this viewpoint as "a measure of the demand made upon the mind for work" (Freud 1905, p. 168). Later, *Durcharbeiten* is

defined as the transformation of the quantity of energy, which enables it to be controlled through diverting or binding it. Two levels are thus distinguished:

1. The transformation of somatic energy into a psychic quality.
2. The growth of associative pathways, the establishment of which can take place only if this transformation has first occurred.

After the introduction of the concept of narcissism (Freud 1914a), the notion of psychic working through provided a point of contact between the economic frame of reference and the problem of providing or altering meaning in the sphere of representation. After the second drive theory had been worked out (Freud 1920), it became possible to see an analogy between what Freud understood by the work of the cure as *Durcharbeiten* and the mode of spontaneous functioning of the psychic apparatus—the latter being the therapeutic element in the classic meaning described by Baruch Spinoza (1677), who spoke of it in terms of the *growth of being*.

As I see it, the therapeutic action of psychoanalysis is, in essence, a functional aspect of the psychoanalytic process. Its effects are the heightening and improvement of psychic functioning, which go hand in hand with an enhanced capacity to accept and cope with the conflicts inherent in life. For me, this Freudian concept remains current and valid. I am among those who think that no theory of therapeutic action can be proved, which is why I remain skeptical about research in the field of psychoanalysis that passes itself off as "empirical." I believe that the way in which we understand therapeutic action correlates with our understanding of both the psychic apparatus and the clinical process of the cure. This understanding differs, then, from one psychoanalytic school to the next and from one theoretical frame to the next. The principal difficulty here does not seem to be one of divergences among us, which can be sufficiently described, but relates to the fact that,

whatever one's theoretical frame, each analyst works with theories of which only some are conscious, while others remain implicit.

I find this issue important for two reasons: first, because it relates to the problem of broadening the notion of countertransference and its use; and second, because it is through what is implicit and unconscious in the theory of countertransference that I see the only satisfactory answer to the "impossible" question: what is it that lets one psychoanalyst recognize that another has carried out successful clinical work, despite our sometimes contradictory differences?

I have had the experience more than once of listening to theoretical discussions of colleagues from different schools, and telling myself that what we think of as analytic theory can be light years apart. Then, when I would speak in depth with one colleague, I would often see in his narrative of a session that what he was doing was in fact psychoanalytic work, even if his interpretive modalities were not those to which I was accustomed. Likewise, it has happened that I have felt myself to be in very close agreement with the clinical approach discussed by a colleague for whose theoretical positions I could feel only disapproval.

The singularity (or originality) of a theoretical corpus in the field of psychoanalysis is that what is explicit *and* what is implicit both find their way into the unconscious portion of countertransference. This distinctive factor shapes our way of understanding and interpreting the material, one dimension of which is a matter of what one might call the technical implications of the theory. However, a more obscure part of our theories also exists, a part that in all likelihood is related to the unanalyzed residues of our transferences to our own analysts—indeed, to our unconscious identifications or counteridentifications with certain masters whose thinking we identify with.

I call this obscure portion of our theories a *transferential-countertransferential, theoretical-clinical magma*. This magma (if I may be permitted the expression) is beyond our control, and, as such, it can be quite annoying, but it also provides an element of surprise in the cure. My tendency is to think that two psychoana-

lysts who "speak foreign psychoanalytic languages" may nevertheless share a clinical "moment of reprieve," and that this moment of reprieve is related to their respective forms of magma, rather than to a basic theoretical equation.

I reject explanations based on evoking the relationship between analyst and analysand. It is not that I think the relationship is meaningless, but in no case do I consider that it can give us serious and valid theoretical information about a psychoanalytic process or the therapeutic effects of this process. What the patient says is understood as conscious and manifest, but his speech is sustained by unconscious fantasies that require analysis. The same holds true for the countertransference: a portion of it remains hidden from view, and so certain rationalizations—because they are blind spots—should be submitted to self-analysis. These rationalizations occur, notably, in the domain of our unconscious desires in relation to the patient.

## PSYCHOANALYTIC DEVELOPMENTS SINCE FREUD

If, within Freud's work, there already exists an evolution of the notion of psychic working through, and, consequently, of the therapeutic action of psychoanalysis, then this evolution becomes more thoroughgoing with the great thinkers who have succeeded him. In Europe, Klein first broadened the concepts of projection and introjection, and she introduced the notion of projective identification. These developments mark the basis for a more systematic study of—and of a more extended use of—countertransference.

In a much different way but following Klein, Winnicott and Bion considered the concepts of projective identification and countertransference in a wider sense, thus admitting the idea that a patient's unconscious fantasies affect the psychoanalyst's psyche. Moreover, if they can be worked through, these fantasies will provide fruitful information concerning the analytic situation and the patient's psyche. Green, while working with borderline and nonneurotic patients, found that the notion of transference needed to

be redefined. This finding subsequently enriched our consideration of the psychic working through of the countertransference, which was broadened to include all parameters of the psychoanalytic situation. In a highly meaningful passage, Green (2000) writes:

> The analyst must fill in the lacunae in [the patient's] memory, and overcome the resistances of what has been repressed. One had to wait a rather long time—until "Constructions in Analysis" (1937)—before getting over an absolute removal of infantile amnesia so as to reconstitute a complete history. However, Freud had long before seen that, when trauma occurs prior to the acquisition of language, recollection is quite impossible. Only the analysis of the resistances will uncover the roots of the neurosis. Transference, in certain cases, . . . means bringing up-to-date rather than recollection, for the analysand does not see in it a return of the past; he refuses to confer to what he has lived the quality of a repetition. Rather, he sees it as a new phenomenon that can be explained in and of itself, without needing to think of it as a return of the past. We might very well call this phenomenon an *amnesiac recollection outside the field of conscious and unconscious memories*. [p. 108; translation by Steven Jaron; italics added]

Green's commentary greatly enhances our view of how the countertransference is worked through psychically, which can thus no longer be limited to negative or affective effects of the patient on the analyst, but extends to the entirety of the analyst's psychic activity during the session, and sometimes between sessions.

The following brief example from my own clinical practice illustrates the kind of psychoanalytic work Green has in mind.[1]

*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

[1] I have previously discussed this clinical example (see Aisenstein 2003).

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 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 sup-

pressed. 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.

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. True, it has much to do with aftereffects: what in French we call *après-coup,* and whose force French analysts strongly hold to, and which, I think, are frequently found in the analyst's mental functioning. They make it possible to break down an area of unconscious collusion between the two protagonists. This, in fact, is the kind of work that took place with Vanya. I uncovered (as I wrote out the sessions) an affect that I had suppressed and forgotten. But I later spoke to the patient about the sensation of nausea that he had also suppressed.

### *Elaborating Freud's Thinking*

Clearly, then, this entire conception of how psychoanalysis is carried out differs from Freud's (1914b) definition of psychic working through. It necessarily leads us to reconsider the work of interpretation, which, far from having a bearing only on resistance, consists in a painful process of binding (Freud's *Bindung*) and unbinding elements—what I call *microtrauma*—from a field of thought co-generated with the patient. By *co-generated,* I mean that, in the context of the frame of the session, the patient's psychic working through is sustained, completed, and revived by the preconscious of the analyst. This may not be an entirely new concep-

tion, but it illustrates well that the evolution of psychoanalytic thought is not restricted to broadening the clinical field to include increasingly difficult and more unconventional cases; in fact, this evolution also involves a change in the aims 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 defined by the analytic 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 co-creates a previously absent meaning with the patient, we must reconsider our view of the mechanism of therapeutic action (see Green 2000). The potential benefits of psychoanalysis are not easily reduced to an explainable symptomatic cure—bearing in mind, once again, that such a cure, according to the classic medical model, is defined as a return to the previous state. Therapeutic action must instead be defined as the gradual understanding of and expansion of the psychic field. The patient comes to appreciate the value and meaning of his or her mental life, including the infinite complexity of the psyche and the pleasure one can have in *thinking*. Freud's (1938) final concept of Eros as a binding force and of the death drive, which creates rupture, should, I believe, be understood as an attempt to assign metapsychological status to the process of thinking and thought.

## LACAN'S INFLUENCE ON FRENCH PSYCHOANALYSIS

### *On Therapeutic Action*

The phenomenon of Lacan and his profound effects on the whole of psychoanalysis in France are interesting to note. I wish first to mention the return to Freud advocated by Lacan, which

strongly emphasized the rereading of and constant reference to Freud's theoretical corpus. The celebrated statement in French psychoanalytic work—"The removal of the symptoms of the illness is not specifically aimed at, but is achieved, as it were, as a byproduct if the analysis is properly carried through"—is from Freud (1923, p. 251), but it was highlighted by Lacan (1953). When it is understood as a Lacanian necessity—that the psychoanalyst should be interested in the psychoanalytic process and not therapy—its consequence (which in my view is beneficial) is that of not distinguishing what is *psychoanalytic* from what is *psychotherapeutic*. I wholly agree with this position. It is, moreover, Freud's. There is but one psychoanalytic process and it is therapeutic in itself. Psychoanalysis is the best psychotherapy; and as to its details (of the frame), decisions are made in relation to the psychic organization of the individual patient.

*On Transference and Countertransference*

In Lacan's works, we come across a different theory of transference: Transference is not, in nature, something that has previously been experienced (see Lacan 1977). Transference is the patient's answer to the analytic situation—an answer that comes to the patient who is "in love" with the knowledge he or she attributes to the analyst. Although I find this idea interesting, I would nevertheless contest its implications for technique. For Lacan, transference must not be interpreted, because that would lead the patient to identify with the analyst's self. Moreover, countertransference is but an alibi and a mystification.[2] As I see it, the technique that stipulates varying the length of sessions substitutes for the study of countertransference in the session.

*On Interpretation*

For Lacan, the "objectifying" position of the psychoanalyst is a source of alienation. He is critical of interpretations containing the least bit of suggestion. He contests the notion of "becoming

[2] See also Diatkine (2001).

conscious," which does not seem necessary in order for an interpretation to be effective. An interpretation is given not to be understood, but to *make waves* (Lacan 1973).

Lacan's influence on French psychoanalysts, even among those most critical of him, is apparent in how we phrase our interpretations. Diatkine (2001) has compared the interpretive style of a French analyst, de M'Uzan, to that of a British analyst, Joseph (see Diatkine, pp. 397*ff.*). In more or less analogous circumstances, Joseph explains to her patient what is happening between them—pointing out to her that, appearances not withstanding, she resists her analysis—and shows the patient what she is defending against; while de M'Uzan's interpretation does not explain anything at all. De M'Uzan's interpretation is associative and, through its double meaning, it strikes straight at a sexual content quite far from the conscious discourse of the patient.

De M'Uzan holds that explanatory interpretations touch upon only the conscious elements of thought, and that they therefore run the risk of lacking the transformational impact associated with the element of surprise, which is necessary if an interpretation is to be effective. The interpretation's impact is sensed along the border between the unconscious and the preconscious, with the psychoanalyst working there through primary identification. As de M'Uzan (1999) writes:

> When regression threatens to affect not only the ego of the analysand but also, most often but to a lesser degree, that of the analyst—and I consider this wholly desirable—then the latter ought to inflect the style of his interpretation or, rather, accept this change, the elements of which escape his control. It is in these moments that more or less clear phenomena of depersonalization, which are more or less shared, appear. It should be noted, however, that the interpretations can sometimes take on a pseudodelirious appearance. They are delirious, but in this sense what happens is quite the contrary to what occurs with the deeply psychotic patient, who *objectifies* his ego by placing it in the object. No, the analysand listens to the interpretation in order to make it *subjective*. The analyst must thus be ca-

> pable of "functioning" through *primary identification*. But this is risky, and it is why I would qualify this way of working as "a policy at the edge of the abyss." [pp. 109-110; translation by Steven Jaron; italics added]

De M'Uzan's is an extreme position, and it has many strengths. But I do not wish to say that all French psychoanalysts carry out the act of interpretation in the way he advocates. When I make an interpretation, I seek, in certain cases, to speak to the secondary process, and thus to how the patient views his own functioning, which has the advantage of working on his narcissism. That said, the notion of "understanding" at the level of secondary process seems less important in this model than elsewhere. This aspect of psychoanalytic practice seems to be one of the effects of Lacan's presence in the history of psychoanalysis in France.

## Kulturarbeiten *and Therapeutic Action*

As mentioned, Lacan brought to light Freud's idea that the cure is a byproduct of analysis. In my view, Lacan was emphasizing the idea that the analytic process, which is a broadening of the field of thought—itself the work of culture—is an end unto itself; Freud (1929) used the term *Kulturarbeiten*. What is therapeutic, the initial aim of the cure, may be thought of as an endeavor bearing on the very nature of the psychic processes. The question is not whether a psychoanalytic psychotherapy is effective, but whether the analyst should initiate a psychoanalytic psychotherapy or a psychoanalysis, a decision that must be based on an evaluation of the psychic functioning of the patient.

I see therapeutic action as an indisputable truth, and yet our view of therapeutic action can only be a subjective one. We do not possess the tools for measuring how the patient's field of thought has changed. Given that psychoanalytic principles were discovered while "in connection with sick people," as Freud (1933, p. 157) wrote, it is consequently "undone" from its primary objective, which it surpasses, as we read in the prophetic text *Civilization and Its Discontents* (Freud 1929).

Already in section three of *The Philosophy of Nature*, Hegel (1819) asked if a stone could fall ill. His answer was that, as a dead organism whose existence is singularly objective, a stone cannot become sick. It simply *is*—or it decomposes. It differs from a being possessing subjectivity insofar as such a being is affected by illness not only in relation to its body, but also in its being-in-the-world. The latter is modified by illness and through healing.

Zaltzman's (1998) definition of psychoanalytic healing as a psychic revolution is relevant. If we do not want psychoanalysis to become a mere shadow of itself, then we can no longer limit it to the model of neuroses, nor must it be restricted to the way that Strachey (1934) defined its therapeutic action. Perhaps we now ought to admit that a profound revision of the objective of psychoanalysis has occurred, and also that the nature of its therapeutic aims has changed. As Zaltzman points out, the analyses we carry out today differ necessarily from those carried out before the Second World War. Civilization has changed and, with it, how we conduct a cure.

## SUMMARY

French psychoanalysis has greatly evolved since the end of the Second World War. The agents of change have been diverse. Lacan, as I have tried to show, is one; but certain Anglo-Saxon analysts, notably Klein, Winnicott, and Bion, also count among them. Winnicott, above all, brought our attention to the detailed study of countertransference, as well as to what processes can be mobilized when working with unconventional patients. Bion emphasized how important thought processes are. At the same time, the Psychosomatic School of Paris—with the introduction of concepts now regarded as classic, such as mechanical thinking and essential depression (that is, a depression without affect and without suffering)—brought to light an economic perspective of mental functioning. And by placing emphasis on negative narcissism, destructiveness, and disobjectifying, Green founded a contemporary conception of psychoanalysis as a fundamental science of the psyche.[3]

[3] For the most recent summary of his conception of psychoanalysis, see Green (2002).

Freud thought of psychoanalysis as both a method and an investigative process. The cure proceeds from the transformation—by first passing through formal regression—of what is mute in the psyche into the phenomenon of language. This implies a deepening of our knowledge of *Vorstellung* (*idea* or *presentation* in English)[4] and the capacity for mental visualization—or what we call in French *la figurabilité psychique*. Green's work attests to psychoanalysis's simultaneous grounding in the biological sciences, in neurobiology and neurophysiology, on the one hand, and in the social sciences, in linguistics, semiotics, and anthropology, on the other. These new conceptions demonstrate that psychoanalysis is inconceivable without a theory of thought.

This is in keeping with the historical evolution of the world. Clinical practice today obliges us to take seriously attacks against thought, which originate as much from within one's psyche as from the cultural environment in which one lives. Here the therapeutic action of psychoanalysis is indispensable. Analysis is uncompromising in relation to other therapies because it alone aims, other than bringing relief from a symptom, at aiding our patients to become, or to become again, the principal agents in their own history and thought. Am I too bold in insisting that this is the sole inalienable freedom a human being possesses?

The clinical vignette discussed in this essay seeks to illustrate how the psychoanalytic method can be used in the face of profound, unconventional troubles in mental functioning that damage one's capacity to think. For the philosopher Hannah Arendt (1978), living and thinking are, moreover, one and the same thing.

## REFERENCES

Aisenstein, M. (2003). Does the cure come as a byproduct of psychoanalytic treatment? *Psychoanal. Q.*, 72(1):263-274.

Arendt, H. (1978). *Life of the Spirit, Vol. 1: Thinking*. New York: Harcourt, Brace & Jovanovich.

[4] For a concise discussion of *Vorstellung*, see Laplanche and Pontalis (1967, pp. 414-416).

DE M'UZAN, M. (1999). L'interprétation? Question de formulation. In *Interprétation vol. I: un processus mutatif,* ed. G. Pragier, L. de Urtubey & S. Wainrib. Paris: Presses Universitaires de France.

DIATKINE, G. (2001). Les lacanismes, les analystes français et l'Association psychanalytique internationale. In *Courants de la psychanalyse contemporaine,* ed. A. Green. Revue française de psychanalyse-numéro hors-série. Paris: Presses Universitaires de France, pp. 389-400.

FREUD, S. (1900). *The Interpretation of Dreams. S. E.,* 4/5.

——— (1905). *Three Essays on the Theory of Sexuality. S. E.,* 7.

——— (1914a). On narcissism: an introduction. *S. E.,* 14.

——— (1914b). Remembering, repeating and working-through. *S. E.,* 12.

——— (1920). *Beyond the Pleasure Principle. S. E.,* 18.

——— (1923). Two encyclopaedia articles. *S. E.,* 18.

——— (1929). *Civilization and Its Discontents. S. E.,* 21.

——— (1933). *New Introductory Lectures on Psycho-Analysis. S. E.,* 22.

——— (1937). Constructions in analysis. *S. E.,* 23.

——— (1938). *An Outline of Psycho-Analysis. S. E.,* 23.

GREEN, A. (2000). Transfert, répétition, liaison. In *Le Temps éclaté.* Paris: Minuit.

——— (2002). *Idées directrices pour une psychanalyse contemporaine: méconnaissance et reconnaissance de l'inconscient.* Paris: Presses Universitaires de France.

HEGEL, G. W. F. (1819). *The Philosophy of Nature.* Whitefish, MT: Kessinger Publishing, 2004.

LACAN, J. (1953). Variantes de la cure-type. In *Écrits.* Paris: Gallimard, 1966, pp. 323-362.

——— (1973). Conférences et entretiens dans les universités nord américaines. *Scilicet,* 6/7:5-63.

——— (1977). *Écrits,* trans. A. Sheridan. London: Tavistock.

LAPLANCHE, J. & PONTALIS, J.-B. (1967). *Vocabulaire de la psychanalyse.* Paris: Presses Universitaires de France.

SPINOZA, B. (1677). *Ethics.* Oxford, England: Oxford Univ. Press, 2000.

STRACHEY, J. (1934). The nature of the therapeutic action of psychoanalysis. *Int. J. Psychoanal.,* 15:127-159.

WINNICOTT, D. (1952). *Les Lettres Vives,* trans. J.-B. Pontalis & M. Gribenski. Paris: Gallimard, 1989.

ZALTZMAN, N. (1998). *De la guérison psychanalytique.* Paris: Presses Universitaires de France.

---

*72 Rue D'Assas* *–and–* *1 Xenia Street*
*75006 Paris, France* *Athens 11527, Greece*

*e-mails: mariliaais@hotmail.com*
*marilia.aisenstein@gmail.com*

*Psychoanalytic Quarterly, LXXVI, 2007*

# ON THE THERAPEUTIC ACTION OF PSYCHOANALYSIS

BY CLÁUDIO LAKS EIZIRIK

*The author discusses therapeutic action as addressed in contributions by Klein, the post-Kleinians, and Willy and Madeleine Baranger. He highlights the roles played by psychoanalytic listening and psychoanalytic neutrality in therapeutic action, and presents a detailed clinical vignette to illustrate his points.*

## INTRODUCTION

When Freud (1912) recommended the adoption of a state of *evenly suspended attention,* he meant that the analyst should be open to whatever arises, without prejudices of any kind, and without systematically seeking confirmation of any previous hypothesis. Adopting this position could help him in the delicate and what is even now the somehow mysterious process of the therapeutic action of psychoanalysis.

In his seminal paper of 1934, Strachey stated that the final result of a psychoanalytic treatment is to enable the patient's whole mental organization, which had been held in check at an infantile stage of development, to continue its progress toward a normal adult stage. The principal effective alteration consists, according to Strachey, in a profound, qualitative modification of the patient's

---

Cláudio Laks Eizirik is a Training and Supervising Analyst, Porto Alegre Psychoanalytic Society; Adjunct Professor at the Department of Psychiatry, Federal University of Rio Grande do Sul, Brazil; and President of the International Psychoanalytical Association.

superego, from which the other alterations would follow—for the most part, automatically. This modification of the patient's superego is brought about in a series of innumerable small steps through the agency of mutative interpretations, which are effected by the analyst by virtue of his position as the object of the patient's id impulses and as an auxiliary superego. However, according to Strachey (1934), the fact that the mutative interpretation was the ultimate operative factor in the therapeutic action of psychoanalysis does not imply the exclusion of many other procedures (such as suggestion, reassurance, abreaction, etc.) as elements in the treatment of any particular patient.

From then on, several authors, following along these and many other lines, suggested ways in which the analyst could come closer to what the patient tries to communicate, and thus could operate more effectively in order to produce psychic change in the patient. All these contributions—coming from different psychoanalytic schools—help us today, in our daily work, to attempt an analytic technique that aims at therapeutic action.

In this article, I will briefly review some contributions from Klein and from post-Kleinian authors, and then outline in some detail the ideas put forward by Baranger (1993), Baranger and Baranger (1961-1962, 1979), Baranger, Baranger, and Mom (1983), and by other Latin American authors. Finally, I will present clinical material in order to illustrate the ways in which I think psychoanalysis acts therapeutically.

## KLEIN'S CONTRIBUTIONS

Klein's (1950) views on therapeutic action are indirectly stated in a presentation she made on the termination of analysis:

> Have persecutory and depressive anxieties been sufficiently reduced in the course of the analysis, and has the patient's relation to the external world been sufficiently strengthened to enable him to deal satisfactorily with the situations of mourning arising at this point? By analyzing as fully as possible both the negative and the positive trans-

> ference, persecutory and depressive anxieties are diminished and the patient becomes increasingly able to synthesize the contrasting aspects of the primitive objects, and the feelings towards them, thus establishing a more realistic and secure attitude to the internal and the external world. If these processes have been sufficiently experienced in the transference situation, both the idealization of the analyst and the feelings of being persecuted by him are diminished; the patient can cope more successfully with the feeling of loss caused by the termination of the analysis and with that part of the work of mourning which he has to carry out by himself after the end of the analysis. [p. 204]

It is evident, then, that the therapeutic action of psychoanalysis, according to Klein, occurs through rigorous maintenance of the analytic setting, so as to keep transference as pure and uncontaminated as possible. She emphasizes transference as the central focus of analyst–patient interactions; demonstrates her belief that the transference situation is active from the beginning of the analysis; advocates the analyst's attitude of active receptivity, rather than one of passivity and silence; supports the interpretation of anxiety and defense together; and, mainly, *she emphasizes transference interpretation as the agent of therapeutic change* (Segal 1967).

## POST-KLEINIAN DEVELOPMENTS

More recently, post-Kleinian analysts, without radically changing these basic points, have developed new ways of understanding psychic life, and, as a consequence, of explaining the therapeutic action of psychoanalysis. For instance, many authors have discussed the importance of what the patient does in contrast to the content of what he says. Joseph (1975, 1985) particularly emphasized this contrast as a starting point for her understanding of the way patients—from very early on, both in their lives and in the analytic situation—adapt to their objects and attempt to control them through projective identification, a mechanism first described by Klein (1946), but whose full usefulness was developed only later, in Bion's (1959) container/contained formulation.

Joseph's aim is to discover where the alive, immediate emotional contact between patient and analyst lies, this being a prerequisite of true understanding. She stresses that much of what the patient communicates in a session is not expressed in words themselves, but through the use of words to carry out actions—that is, to do something to the analyst, or to put subtle pressure on the analyst to do something to the patient. The analyst's task is to accept the pressure to do or to feel some particular thing, to reflect on the fact that he is being subjected to it, and then to make a limited and precise interpretation only about the immediate action.

Joseph avoids interpretations with two or more contrasting statements and premature links with bodily expressions and conceptualizations of unconscious fantasy and with known facts of the patient's history, which she calls *plausible interpretations*. She does so because, in her view, both patient and analyst lose the immediate emotional reality when such interpretations are made; they both gain what is, in effect, a safe theoretical distance from a third person: the patient. Her method particularly stresses the patient's repetition of infantile defenses—that is, the attempt to draw the analyst into behavior that will evade painful emotional confrontations by maintaining or restoring an age-old system of psychic defense (Joseph 1975, 1985; see also Spillius 1988). Continuous analytic work along these lines shows the analyst how to accept therapeutic limitations by learning to contain and to use constructively his feelings of therapeutic discouragement. This will bring about the patient's slow and consistent psychic change; thus, this approach may be seen as Joseph's way of formulating the therapeutic action of psychoanalysis.

## THE BARANGERS' VIEWPOINT

Willy and Madeleine Baranger (1961-1962), analysts of French origin who trained in Argentina, presented two main concepts that can shed light on the therapeutic action of psychoanalysis. Their concepts of the *dynamic field* and *unconscious fantasy* represent the convergence of various contemporary currents of thought,

such as the ideas of Kurt Lewin, Gestalt psychology, and elaborations of ideas first put forward by Klein, Isaacs, and Bion.

Baranger and Baranger described different aspects of the analytic field: its spatial aspect, resulting from the particular features of the physical environment of the consulting room and variations in distance or proximity between analyst and patient; its temporal dimension, as indicated by the rhythm and length of sessions and the separations or interruptions occurring within the analytic process; and its functional configuration, due to characteristics of the setting—i.e., the different roles assumed by patient and analyst.

The main focus of the Barangers' interest, however, was the study of the unconscious dynamic of the psychoanalytic field. Their central hypothesis was that the regressive situation of the analysis gives rise to a new gestalt, a bipersonal or basic unconscious fantasy of the couple, different from the fantasies of the patient or of the analyst considered individually. This fantasy underlies the dynamics of the analytic field—whether it be in motion or in stasis. This notion was inspired by descriptions of the mechanism of projective identification (Klein 1946) and of the concept of unconscious fantasy (Isaacs 1948) as an expression of the totality of mental life, comprising both instinctual (libidinal and destructive) impulses and mechanisms of defense against these impulses.

The Barangers saw the analytic field as the stage for the *mise-en-scène* of the patient's primitive fantasies. The assumption that unconscious fantasies are brought into the present in the analytic field lies at the root of one of the main characteristics of the field, that is, its radical ambiguity—in the sense that everything and every event in the field can be understood at the same time as being or meaning something else.

The Barangers' approach differs to some extent from those of Klein and Isaacs in its emphasis on the idea that the analyst needs to understand not only the projection of the patient's fantasies, but also the processes arising between patient and analyst. This shared unconscious fantasy is conceived as a new structure that

> . . . can in no way be regarded as determined by the patient's (or, of course, the analyst's) instinctual impulses, al-

> though the impulses of both are involved in its structuring. Nor can it be seen as the *sum* of the two internal situations. It is something created *between* the two, within the unity they constitute during the session—something radically different from what each of them is individually. [Baranger and Baranger 1961-1962, p. 20, italics in original; see also De León 2002.]

As a consequence, the words of the interpretation not only disclose the unconscious contents of the patient's psychic reality, but are also a form of *doing with the patient*. The interpretation must be fundamentally directed toward the here and now of the relationship with the analyst. The analyst's attention must be focused on the present of the analytic situation, and not on the discovery or reconstruction of facts from the past, or on the regressive reproduction of the fixation points and libidinal stages of infantile development.

The importance assigned to the analyst's participation led the Barangers to examine the role of countertransference as an instrument of technique. The analyst, to the extent that he is the depositary of different aspects and objects of the patient's self, assumes a multiplicity of varying functions. Thus, he must continuously observe his countertransference if he is to understand the successive unfolding of the patient's fantasies. In later formulations, the Barangers (1979) and Baranger, Baranger, and Mom (1983) stressed the importance of maintaining analytic asymmetry. Taking into account Racker's idea of counterresistance, they showed that the link between the patient's resistance and the analyst's counterresistance can contribute to either's becoming chronic. This gives rise to the formation of a bulwark in the analytic field, maintained by both patient and analyst. Baranger, Baranger, and Mom (1983) defined this bulwark as a sort of neo-formation set up around a shared fantasy assembly that implicates important areas of the personal history of both participants, attributing a stereotyped, imaginary role to each.

Baranger (1993) suggested that the attitude of analytic listening —an important part of the way psychoanalysis acts therapeutically —is diametrically opposed to the mental position of the observer

or experimenter in the physical and natural sciences. The scientific observer plans his observations and experiments on the basis of his expectations, which depend both on his general knowledge of his discipline and on the idea or discovery that he considers may cause his science to progress. He works with prior concepts that organize the same observation in order to verify or falsify them. However, the psychoanalyst must beware of mentally obstructing access to the unforeseen or to the experience of surprise, which is precisely what he hopes for as a characteristic of the emergence of the unconscious.

But, as Baranger stressed, analytic listening is not a passive or naive form of listening. It is, in fact, guided by the analyst's full listening resources, among them the analytic theory that provides him with an implicit framework with which to accommodate his discoveries. Each analyst develops a scheme of reference, according to Baranger, which is made up of his theoretical allegiances, his knowledge of analytic literature, his clinical experience (especially his failures), what he has been able to learn about himself in his personal analysis, and his identifications with his own analyst and clinical supervisors, as well as the theoretical fashions that periodically sweep through the psychoanalytic movement. My own approach to analytic neutrality (Eizirik 1993) attempts to include an emphasis on the difficulty of—and yet the unavoidable need for—keeping a certain critical distance away from analytic theories that might impair our listening.

What does the analyst listen to? Baranger (1993) proposed that what defines analytic listening and distinguishes it from that of any other kind of psychotherapy is that it attempts to listen to the unconscious. In other words, the analyst listens to something other than what he is being told. But to imagine that he seeks a latent content that exists behind the manifest content would be to reify something dynamic. The unconscious is not *behind,* but is elsewhere. Instead of referring to the well-known spatial metaphor of the structure of the mind, Baranger suggested that we seek out unconscious meaning that appears somewhere in disguise—as a sort of riddle that the analyst is challenged to solve.

The listening of the analyst consists, then, in decentering the patient's discourse and stripping it down in order to find a new center, which in this moment is the unconscious.

Three factors are involved: (1) the patient's explicit discourse; (2) the unconscious configuration of the field (the unconscious fantasy of the field), which includes the transference/countertransference; and (3) what corresponds at this point to something unconscious in the analysand, which must be interpreted. It is by virtue of the mediation of the unconscious configuration of the field that the patient's unconscious can express itself and the analyst can compose an interpretation. These are the main elements that take part in the therapeutic action of psychoanalysis, as formulated by Baranger and Baranger (1961-1962, 1979).

## A CONTRIBUTION BY FAIMBERG

I would like to turn now to a contribution by Faimberg (2005), who links the function of psychoanalytic listening to Freud's concept of *Nachträglichkeit*. Faimberg defines *Nachträglichkeit* as the retroactive assignment of meaning, rather than mere deferred action, and she derives the notion of *listening to listening* from the combination of these two elements. She proposes a dialectical conception of time, with interpretation involving three logical phases, which are respectively incumbent on the analyst, on the patient, and on both. So the patient speaks and listens from a position dictated by his unconscious identification, which also causes him to reinterpret the analyst's interpretations and his silences.

By listening to the patient's reassignments of meaning to his interpretation, the analyst can discover the patient's unconscious identifications and, together with the patient, thereby facilitate the process of psychic change. Through the function of *listening to listening*, Faimberg proposes that it is possible to overcome the dilemma of whether the analyst (with his interpretation), or the patient (with his own reinterpretation of it), is the one who is right.

## MY VIEW OF THERAPEUTIC ACTION

I will discuss some of my contributions regarding psychoanalytic neutrality, since I think this may help us understand why the notion of therapeutic action in psychoanalysis is such a difficult one. I have been considering the problem of analytic neutrality since 1993, in successive papers, and in spite of recent criticisms of this concept, I still see it as an important tool—once we accept the need to include several elements in it, and also its unavoidable ambiguity. In my view, analytic neutrality is not only a behavioral position, but also an emotional one—from which the analyst, in his relationship with the patient, without putting aside the necessary empathy, observes the following features, while still keeping a certain distance in relation to each of them:

1. The patient's material and his transference;
2. The countertransference and the analyst's own personality;
3. The analyst's values;
4. The expectations and pressures from the outer environment; and
5. Psychoanalytic theory (or theories).

It must be stressed that only continuous psychic work around these five points can grant the analyst the possibility of utilizing analytic neutrality as a tool and an aim at the same time.

Such a position does not imply an absence of spontaneity or naturalness. Instead, an awareness of the importance of maintaining *a certain possible distance* in relation to those five aspects is what permits us to achieve an increasingly deeper contact and communication with the patient's inner world; this awareness therefore targets the therapeutic objectives of both analyst and patient. I use the phrase *a certain possible distance* here as a deliberately ambiguous expression; it admits the need of a distance, but acknowledges that this is relative. At the same time, with the word *possible,*

I attempt to emphasize that we are dealing with a position constantly threatened, by both inner and outer influences, which we try to keep under control as much as we can.

The patient's material and his transference constitute, par excellence, the field of the psychoanalytic process. Free-floating attention is the instrument that permits the analyst to follow the patient's associations and his movements, both through the session and through the process. When we listen, using all technical and personal instruments developed in the course of psychoanalytic training, and necessarily being rooted in successive life and professional experiences, we are also acting as scientists who observe. I think it is a mistake to suppose that the scientific attitude has been replaced by a different one; rather, the observer's subjective dimension has been added to the observation, just as has happened in other fields of knowledge and research. But, in its essence, the search for a possible objectivity is still going forward.

Countertransference, considered as a set of emotional reactions provoked in the analyst by the patient, is one of the most important additions to the psychoanalytic field, serving as an instrument of observation and information about the patient. However, there must be a distinction between the analyst's countertransference and his own personality—in both its healthy and pathological aspects. The risk of not thinking about this aspect of countertransference is the temptation to consider it as proof of what is happening with the patient (and here I am reminded of Steiner's [1992] warning).

The analyst's ability to adequately utilize countertransference depends on the extension and depth that his personal analysis reaches, as well as on the self-analysis that should subsequently be performed. The analyst's personal issues (or his *personal equation,* already mentioned by Freud in 1926) are aspects deserving constant attention. In particular, the narcissistic elements stressed by Rosenfeld (1987) have been shown to be potentially the most harmful to the maintenance of true psychoanalytic neutrality. In my view, countertransference is also influenced by issues of gender and the different stages of the life cycle (Eizirik 1995).

In the foregoing sections, I have outlined the main elements that I take into account in considering the ways that psychoanalysis can act therapeutically. Let us now see how these ideas can help us by examining a sample of clinical material.

*Clinical Example*

The patient, Ms. C, in her early fifties, has been in analysis for many years and has made important psychic changes. She is considering ending the analysis—an idea that has thus become present in the analytic field.

This is a Monday session, one week before the summer break. Ms. C begins the session by telling me about the weekend, during which she had a long conversation with her husband, who was complaining about his own therapist and thinking of ending his treatment. In spite of consciously knowing that he has many emotional problems, Ms. C agreed with him, encouraged him to end his treatment, and felt glad in imagining that he could be able to live without therapy.

At this point, I think to myself: how can she be so blind to his real condition? But I keep silent.

Ms. C goes on to say that, afterward, she observed the way in which her husband related to friends, thinking how much he used to speak and behave like a helpless child, which had caused her irritation; at that time, she had criticized him fiercely. On this particular weekend, the patient and her husband had lunch with their only son, D, in his twenties, who told them he was planning to spend some months traveling abroad. Ms. C's husband reacted with hostility to this announcement, saying that he would not help D in this venture. Ms. C got mad at her husband (as she described it) for being unable to appreciate D's progress in his struggle for independence. She again criticized her husband vociferously, just at the moment when he was trying to speak more calmly with their son.

I tell Ms. C that she was mad at herself for not noticing that her husband needed to remain in therapy, and that, possibly, she

was seeing herself in her husband, given that she also wanted to end her analysis, but perhaps was not convinced that this was the best moment for it.

The patient reacts to this interpretation with an intensity peculiar to her, similar to what she showed in describing the lunch. I cannot avoid engaging in a sort of argument with her, trying to show her the way she is behaving toward me and her attempt to deny how difficult it is for her to feel the pain of the prospective end of analysis.

Repeating something she has done in recent sessions, in responding to this interpretation, Ms. C calls me by the name of her husband. When I point out this slip to her and ask her what it might mean, she begins to laugh and says that maybe she is in love with me, adding that this kind of joke would have been unthinkable some time earlier.

"What else could it mean?" I ask. Ms. C replies that maybe she wishes her husband would listen to her and talk with her the way I do, and maybe she wants to feel at ease with him as she does in her analytic sessions.

These comments allow us to analyze Ms. C's feelings of deep commitment to me and to her analysis, something she used to feel with her mother when she was a child, and her fear of losing me and losing all she has achieved in these years. After all, by projective identification, her husband was said to have behaved like a child, and she prefers to see herself as a strong person, able to leave home, just as her son wants to do, and to take care of herself. Furthermore, I point out the fact that we are nearing the summer break, something that could contribute to a feeling of being abandoned. At the same time, the patient is more able to joke and to enjoy life, and when she says that she could be in love with me, she expresses, in a disguised way, how fully we are able to work together in her analysis.

She falls silent after this, seeming somehow distant. The former lively contact, in which we apparently enacted the scene of an arguing couple, is lost at this moment.

*Listening to listening,* as discussed by Faimberg (2005), leads me to think that I am focusing my interpretations on the possibility and the wish of the patient to end her analysis. This is something that, in principle, I am in agreement with, but at the same time I have reservations. In this retrospective look, I have the impression that I might have been dealing with what Joseph (1975, 1985) describes as the *plausible interpretation*, meaning I am running the risk that both the patient and I may lose the immediate emotional reality of the session, and instead participate in what is, in effect, a safe theoretical discussion about a third person, the patient.

What comes to my mind is the fact that something is missing here. The unconscious, as Baranger would say, possibly lay elsewhere, and not where I had imagined I saw it. Yes, the end of analysis is a possibility to take into account, but there is something else as well. And that is, possibly, the relation of the patient with her own internal frail and lonely child—something she sees in her husband.

What leads me to this new hypothesis? It is the slip in which Ms. C called me by the name of her husband, immediately after presenting him as a helpless child. Now I suppose she was telling me: "You might imagine that I am in love with you, or that I wish my husband could relate to me the way you do. This might be a part of it. But you are blind to what really makes me sick, anxious, desperate: it is feeling like a motherless child; I cannot tolerate it. It is not because the analysis will end someday or because there will be a summer break; it is because this is something I have always felt, and I do not know whether someday I will be able to live with it, without using so many defenses. This is what really makes me so anxious, desperate, and full of doubts and uncertainty about myself and my way of feeling and relating to others."

I try to express something of this to Ms. C, and this appears to bring us closer again.

How do we know that this might represent a better understanding of the patient's feelings, mental state, and communications? Only by means of paying careful attention to the subsequent

clinical material, which I did in the following sessions. I was then able to find some evidence that supported this latter understanding.

Moreover, the proposed plausible interpretation had a countertransferential origin because I had a double feeling toward this patient, one that I could identify only after that session: I was concerned that she might be willing to end her analysis before having achieved more solid psychic change, and I was also feeling I would lose a patient with whom so many good analytic hours were happening. These feelings made the optimal position of neutrality difficult for me to maintain at that moment. Only when we allow ourselves to perform the function of *listening to listening* to what is happening in the analytic field are we able to find the best way of identifying with the patient and his internal reality.

Sometimes we must listen to contributions from other fields, as they can also help us succeed in the daily conduct of our profession. As I began writing this paper, I was at the same time reading Philip Roth's novel *The Human Stain* (2000), and I was struck when I found the lines I will quote here. After proposing one of the clues to the dramatic situation that he envisions, and describing the empathic way in which the narrator relates to the main characters, Roth writes:

> How do I know she knew? I don't. I couldn't know that either. I can't know. Now that they are dead, nobody can know. For better or worse, I can only do what everyone does who thinks that they know. I imagine. I am forced to imagine. It happens to be what I do for a living. It is my job. It's now all I do. [p. 213]

In our job as psychoanalysts, if we allow ourselves not only to observe, but to identify and also to imagine, through successive projective and introjective identifications, we might be able to build with each patient a specific analytic field, in which we might aim at doing our best to listen analytically to what is happening in the patient's psychic reality.

## SUMMARY

To summarize my views as described in this paper, I suggest that the therapeutic action of psychoanalysis rests in the unique experience of being listened to and understood by another in a new way, while present in what has been described as the psychoanalytic field, which leads to the patient's acquiring a new understanding of himself, thus reducing his psychic pain and becoming more free to enjoy his own capacities. This is the way through which insight might be obtained as a result of the experience of being understood in a new, fuller way than any previous experiences have provided.

This is one way of formulating the therapeutic action of psychoanalysis—one among many, but the one that allows me to truly appreciate the continuing fascination of our impossible profession.

### REFERENCES

Baranger, M. (1993). La mente del analista: de la escucha a la interpretación. Paper presented at the 38th International Congress of Psychoanalysis, Amsterdam, The Netherlands.

Baranger, W. & Baranger, M. (1961-1962). La situación analítica como campo dinámico. *Revista Uruguaya de Psicoanálisis,* T, IV, no. 1:3-54.

——— (1979). Proceso en espital y campo dinámico. *Revista Uruguaya de Psicoanálisis,* 59:17-32.

Baranger, W., Baranger, M. & Mom, J. (1983). Process and non-process in analytic work. *Int. J. Psychoanal.,* 64:1-15.

Bion, W. R. (1959). Attacks on linking. *Int. J. Psychoanal.,* 40:308-315.

De León, B. (2002). The countertransference: a Latin American view. *Int. J. Psychoanal.,* 81:331-351.

Eizirik, C. L. (1993). Entre a escuta e a interpretação: um estudo evolutivo da neutralidade psicanalítica. *Revista de Psicanálise da Sociedade Psicanalítica de Porto Alegre,* 1(1):19-42.

——— (1995). Masculinity, femininity, and the analytic relationship: countertransferential issues. In *Psychoanalysis in Latin America,* ed. A. A. Garza. Monterréy, México: Psychoanal. Federation of Latin America, pp. 145-160.

Faimberg, H. (2005). *The Telescoping of Generations.* London/New York: Routledge.

Freud, S. (1912). Recommendations to physicians practising psycho-analysis. *S. E.,* 12.

——— (1926). *The Question of Lay Analysis: Conversations with an Impartial Person. S. E.,* 20.

Isaacs, S. (1948). On the nature and function of phantasy. *Int. J. Psychoanal.,* 29:73-97.

Joseph, B. (1975). The patient who is hard to reach. In *Tactics and Techniques in Psycho-Analytic Therapy, Vol. 2,* ed. P. Giovachini. New York: Aronson, pp. 205-216.

——— (1985). Transference: the total situation. *Int. J. Psychoanal.,* 66:447-454.

Klein, M. (1946). Notes on some schizoid mechanisms. *Int. J. Psychoanal.,* 27:99-110.

——— (1950). On the criteria for the termination of an analysis. *Int. J. Psychoanal.,* 31:204.

Rosenfeld, H. (1987). *Impasse e Interpretação.* Rio de Janeiro, Brazil: Imago Ed.

Roth, P. (2000). *The Human Stain.* Boston, MA/New York: Houghton Mifflin.

Segal, H. (1967). Melanie Klein's technique. In *Psycho-Analytic Techniques,* ed. B. Wolman. New York: Basic Books, pp. 188-190.

Spillius, E. B. (1988). *Melanie Klein Today.* London/New York: Routledge.

Steiner, J. (1992). Interpretações centradas no paciente e centradas no analista. Paper presented at Sociedade Psicanalítica de Porto Alegre, Brasil.

Strachey, J. (1934). The nature of the therapeutic action of psycho-analysis. *Int. J. Psychoanal.,* 15:127-159.

---

*Rua Marquês Do Pombal 783/307*
*90540-001 Porto Alegre, RS, Brazil*

*e-mail: ceizirik.ez@terra.com.br*

*Psychoanalytic Quarterly, LXXVI, 2007*

# THE KLEINIAN THEORY OF THERAPEUTIC ACTION

BY R. D. HINSHELWOOD

*The author distinguishes three types of change seen in patients over the course of a psychoanalysis, noting that analysts are most interested in the type that occurs uniquely as a result of the analysis itself. He discusses Freud's views on the analytic relationship and contrasts these with the way the relationship is conceptualized within object relations psychoanalysis, and he compares Freudian views of transference and countertransference with Kleinian ideas. The use of interpretation is also examined from different theoretical viewpoints. The centrality of aggression in the Kleinian view of the psyche is put forth as a potentially controversial aspect of Kleinian technique.*

Therapeutic change is difficult to pin down. Change has various modalities. We encounter at least three kinds, but two cannot be regarded as therapeutic. First, people change from moment to moment depending on the context of the relationships in which they find themselves at the moment and to which they are reacting. If they feel supported, they will be in a different state of mind than if they feel unsupported. This is entirely context specific.

Second, there is a process of long-term change, which occurs through time. Some of this is epigenetic. As time unfolds, so does

---

R. D. Hinshelwood is a member of the British Psychoanalytical Society and Professor in the Centre for Psychoanalytic Studies, University of Essex, United Kingdom.

the psychology, the character, of the individual. This may be partly context—a grandfather has different experiences and develops sublimations and adjustments different to those of a father. An adolescent traverses the *rites de passage* that he must survive culturally and socially not only in order to become a socially recognized adult, but also, internally, to become a person with a significant increment to his sense of self.

Third, we psychoanalysts, in the professional business of influencing people, believe there is a specific and longer-term change that is derived from—and *uniquely* derived from—the encounter that the analysand has with us. It is important that this third kind of change does not become confused with the previous two. Analysts sometimes suffer from such confusion; it is heartening to see a patient changing, and we are tempted to attribute it to our own work. We may mistakenly claim responsibility for changes that would have happened anyway and do not have to do specifically with the therapeutic encounter.

## EARLY DAYS

How can we distinguish the third, therapeutic change from the other two? It may be difficult. One difficulty is that the theory of what therapeutic change *is* has itself undergone a long-term change. Originally, Freud thought that a simple release of emotion was needed by certain individuals whose mental energy was inexplicably blocked. Transference, for Freud (1913), was initially a libidinal cathexis of the analyst, which could be employed as a positive force against the negative influence of resistances in order to lift repressions: "The analytic treatment . . . supplies the amounts of energy that are needed for overcoming the resistances by making mobile the energies which lie ready for the transference" (p. 143). Analysis was then a mechanical handling of forces—*transference* pitted against *resistance*.

Gradually, Freud's view of the analytic relationship changed. He discovered it was a prime site for trouble—and, actually because of that, it could serve as a means for exploring what the trouble was

and working through it. Freud faced that trouble with Dora in 1899, but the lessons he learned took a long time to sink in (Freud 1905). It was especially (and understandably) difficult to theorize the relationship between two people (the analysand with himself) in terms of his current idea of a brain discharging its energy. Wedded as he was to the energy model, Freud persevered with this, later codifying it in his metapsychology papers (1915-1917).

However, in the background, his actual practice in helping people change came under pressure continually from the inescapably personal setting he employed. During the period of "Mourning and Melancholia" (1917) and *Group Psychology and the Analysis of the Ego* (1921), Freud was exploring the importance of identification with objects as much as, or more than, the theory of the libido.[1] It was during this period that Klein began to work psychoanalytically.

From that period on, Freud's colleagues in Vienna began to develop ego psychology, which viewed change as the organization or reorganization of the ego, in order to allow for more flexible defenses and expression of the instincts, easier relations with the superego, and the greatest possible personal fulfillment through sublimations. That trajectory toward ego psychology progressed smoothly up to 1938. Later, it reached a high point around the 1960s and '70s in the United States, supported by the emigrating Viennese analysts who elaborated the economic model and the ego's methods of defense.

## OBJECT RELATIONS PSYCHOANALYSIS

Freud's concept of identification with others and his recognition of the personal pressures within the analytic setting underwent considerable development, often in elaborations by others—notably, Ferenczi and Abraham. Balint and Klein were a second generation of those who strove to understand the "personal" aspects of the ana-

[1] The title of *Group Psychology and the Analysis of the Ego* nicely conveys the basic ambiguity of the time: the conjunction of interpersonal relations with objects, on the one hand, and the libidinal functions of the ego, on the other.

lytic interaction. This strand of psychoanalytic theory has come to be known as *object relations psychoanalysis,* and British psychoanalysis has tended to be held responsible for its emergence and development, with a number of refinements associated with the names of Klein, Winnicott, Bowlby, and Fairbairn. This strand of development—not, in fact, taking place wholly in Britain—gave rise to a reconsideration of the nature of countertransference (e.g., Heimann 1950; Racker 1968), following Freud's death.

Most influential in this development was Klein's technique for child psychoanalysis, in which she offered her patients toys to play with and took the view that, if free association is the natural medium for adults to utilize in expressing their anxiety, the equivalent in children is play. Play, therefore, provided an access into unconscious levels of the child's mind. Anxiety was literally *played out;* and, more clearly than in adult analysis, the nature of the anxiety was displayed in front of the analyst.

However, in spatial terms, using the toys, this display inevitably also involved a display of significant relations among objects. As in many other branches of science, the invention of a new technique of observation produced new phenomena and a new theory. In this case, invention of the play technique led to the development of object relations psychoanalysis. Whereas Klein originally thought she was merely seeking a child version of adult analysis, more recently, object relations analysts have viewed the relations established by adults as analogous to children's play. The "play" an adult engages in with his "toy," the analyst, can be seen as a drama or as the enactment of a narrative between two objects, the analyst and the analysand.

## TRANSFERENCE AND COUNTERTRANSFERENCE

Klein's developments placed greater emphasis on the unconscious elements of the analytic relationship itself; thus, they took off from Freud's discovery of the transference, in all its subtlety, following

his work with Dora. It is true that, after the Dora case—and even after publishing his conclusions from that case (1905)—Freud still used and wrote about his old notions of transference. But he now knew that there was something specific in a transference that connected to an individual patient's neurotic problem. It could develop into a transference neurosis—i.e., a specific manifestation of the patient's disorder within the relationship with the analyst. The Dora case had given Freud the opportunity to see that the analyst (Freud himself) represented a very specific person and role in the patient's experience. Dora reenacted a rebuff, which had a unique resonance with her sense of being exploited. This kind of enacted role has been recognized by psychoanalysis as the specific character of the transference.

Different groups of psychoanalysts debate the proper use of transference. On one hand, there is a belief that the transference is a *usable force* (as described in Freud's papers on technique); on the other hand, there are analysts who regard the transference as a *unique understanding* (and "insight") about that patient's mind. The uniqueness of the transference relationship and the need for insight into it have been stressed by object relations approaches; conversely, what has been stressed more by ego psychologists is the use of transference as a therapeutic force. Although this difference may have been unnecessarily exaggerated at times, it has led to contrasting aims for psychoanalysis.

From a Kleinian point of view, therapeutic change comes from a deeper understanding and insight into the specific roles and relations exhibited and enacted in the transference. That is to say, what is special about the third, therapeutic change spelled out at the beginning of this paper is the increase in insight. This contrasts with a theory that derives from Freud's interest in the structure of the ego. In the ego psychology approach, the aim is to influence the patient's ego to adopt new kinds of defenses and sublimations, and thus to strengthen it against the power of the instinctual id, which demands direct expression and satisfaction. Of course, insight may be used in the service of that end. However, the difference is this: one aim is the strengthening of the ego

through better self-understanding, and the other aim is a strengthening of the ego through better organization of defenses.[2]

*Interpreting the Transference*

Such a distinction can be overdone, since greater insight may be, in fact, the method of strengthening ego defenses. However, we can appreciate the degree of divergence in the two approaches by exploring the work of Strachey (1934) and his idea of mutative interpretation.

The theory behind the idea that ego defenses are weak and need strengthening emphasizes the roles of trauma and fixation. Ever since Freud abandoned his trauma theory, there has been a recognition that trauma can occur as the result of experiences "in fantasy," or what the ego makes of the experience, in addition to the objective nature of the event that gave rise to the experience. The traumatic experience, even if arising in phantasy,[3] has distorted the development of the ego, its strength, and its defenses. Insight into the traumatic memory in the past allows the ego to reform in new ways that were prevented while the trauma was repressed.

So much for the classical ego psychology approach. In contrast to this is the idea pioneered by Strachey (1934) that the patient suffers his traumatizing phantasies *now*. That is, the transference is a replay, like a flashback, of the experience that started the trouble. Thus, insight is directed not so much at the original traumatic experience when the ego was weak, vulnerable, and therefore distorted; insight, according to Strachey, is about the currently

[2] Self psychology would seem to enter into this debate in a slightly different way. Its aim appears to be the strengthening of the ego through specific support of the self-image, which can be achieved by positioning the analyst *on the side* of the patient, as it were. In this case, change comes from using the transference on the side of the patient's narcissism, against negative forces from the superego.

[3] Isaacs (1948) introduced the spelling of *unconscious phantasy* to indicate the specific meaning that fantasy has in the Kleinian literature. As the *mental representation of an instinct,* it has a radically different meaning and connotations to the term *fantasy* in classical psychoanalysis, which can be defined as a *psychological response to frustration.* This spelling convention has been adopted for the purposes of this paper.

active phantasy, which builds the transference into a traumatizing experience now, with the analyst, in current sessions. Such insight could then assist the patient in instituting reality testing of his phantasies. For instance, a patient who sees the analyst as a castrating father will have the opportunity, as a result of insight, to see the analyst also as a helpful figure—which in reality the analyst probably is. Insight, therefore, has the effect of placing reality and phantasy beside each other. Interpretation aids the development of the reality principle, not the readjustment of the defensive structure.

The Strachey point of view derives, clearly, from the emphasis on object relations that are played out in the here-and-now moment of analytic sessions—as in the play technique with toys. Viewing the relationship with the analyst as a flashback in which the two parties are both embroiled *right now* assigns the analyst a very different role from the one who, like an archaeologist, is excavating past trauma from the patient's unconscious memory. There is, of course, a link between the present, here-and-now replay and the unconscious memory of the past; however, Strachey claimed that the immediate aliveness of the confrontation is the mutative moment.

In Strachey's object relations version of analytic interaction, the past might be of interest, but only so far as it illustrates the precise confrontation in the here-and-now present of the analytic moment. According to this view, it is incumbent on the analyst to preserve an image and a way of functioning that does not go along with the patient's expectations. The analyst is expected to be a version of a real person, someone with helpful intent, who is capable of sustaining thought and the presentation of reality while acknowledging the distortion of his own person.

### *The Blank Screen*

According to the more classical notion, transference is a replay of memory that provides an opportunity to understand the trauma *back there and then*. The analyst is required to do nothing, then, that would impede the development of transference,

which is seen as a vivid portrayal of the past. The analyst is a blank screen who can accept any version of an object that the patient is compelled, by unconscious forces, to project onto him. The analyst viewed as an observer who does not interfere with his field of study is playing the same role as a natural scientist, and, in its ideal form, this role takes the analyst as a person out of the field of study altogether. The patient then has to cope with a relationship with a neutral, uninvolved observer—something that may itself be experienced by the patient in a unique way, in accord with his own transference.

Such an injunction to the analyst at one time led to the expectation that the patient could join the analyst in a sphere of activity outside the transference. This was known as the *therapeutic alliance* (Zetzel 1956), in which two neutral, rational observers debated a neurotic patient whose feet were rooted in the past.

*Countertransference*

Freud's injunction to adopt a blank-screen approach, much as a surgeon adopted a steely impassivity, required the analyst to have a very unproblematic relationship with the material and with his own unconscious. It quickly led to the requirement, in the 1920s, that analysts undergo their own analyses in order to eradicate any possibility of their reacting unconsciously to the patient's transference; thus, any unacceptable countertransference was also to be excluded. However, by the 1940s, after a couple of decades of analysts being analyzed, it was evident that analysts were still reacting to their patients, and a different view of countertransference began to be toyed with.

After World War II, there was some concern about dealing with people and societies in a natural-science way; exactly that approach seemed to have led to the social engineering of Nazi Germany and Soviet Russia. As a result, a more "democratic" ethic began to surface in professional life (an ethic that is still on the advance today). So, early on, by 1950, the humanity of the analyst began to be recognized. The analyst's personal aspects were no

longer condemned, but explored as a possible source of information about the transference (Heimann 1950). The analyst's reactions to the patient, it was recognized, might say something about the patient's unconscious, not just about the analyst's unanalyzed problems. With some caution, this point of view was further developed, notably by Money-Kyrle (1956), who described a cyclical process of projection and introjection as the patient speaks and the analyst listens, followed by the analyst speaking and the patient listening.

In this approach, the analyst's function as a blank screen was found to be no longer possible. Countertransference could provide information about the transference. Through examining his own feelings, the sensitive analyst could pick up the role he was expected to play in the patient's transference relationship; so, with safeguards in place, countertransference could be an asset. (Without safeguards, it remains *wild analysis,* as Freud [1910] described it.)

It is important that countertransference feelings are not used as a pretext for the analyst's personal disclosure to the patient. That is not an appropriate way to introduce the patient to the reality of the encounter with the analyst. The patient has, no doubt, been confronted on many, many occasions by others who have given him a "piece of their mind." The psychoanalyst's function is different: it remains the elucidation and articulation of the patient's transference and his idiosyncratic view of the analyst.

Despite this, some analysts from various traditions have debated a good deal about the need for a patient to have an *authentic* response. This is seen as a form of human respect. The patient deserves the respect of the analyst, and it could be argued that the patient has never had such a respectful response from anyone on a reliable basis. By giving the patient an account of his emotional reaction, the analyst hopes to model a good relationship. This is thought to be therapeutic in its own right—and this may be so, though the question remains of whether this modeling of a "corrective" experience is really psychoanalysis. The risk is that it puts a burden of considerable weight on the analyst, who must func-

tion in a mode of complete respect—with which, incidentally, countertransference feelings do not always conform. The analyst has to be sure inside himself that he is not disclosing himself in ways that help him with his unconscious problems.

Given the propensity for analysts to move unwittingly into enactments with patients, to assume one's own feelings are in fact respectful, and not defensive in some way, runs the risk of being exploitive. This risk connects to the argument that Klein made, for related reasons, against the new use of countertransference. She believed that for the analyst to tell the patient what the patient was "doing to" the analyst could serve to attribute the analyst's own problems to the patient's doing.

To safeguard the use of countertransference, it is necessary for the analyst to consider the experience he has in the moment with the patient and to articulate this to himself—and, at the same time, to conjoin this with descriptions of relationships in the patient's material, even if they are at a considerable there-and-then distance. A triangulation process is then established: if the analyst's experience of the patient and the patient's material coincide in some way, we can feel confident that what is common to both will represent something of the patient's transference. Or, at the very least, this is a likely enough circumstance to allow us to venture an interpretation to see if it "works."

## DEEP INTERPRETATIONS

The more classical approach of ego psychology pays close attention to levels of experience and mental functioning. Free association is, of course, conscious; however, it bears the traces of unconscious perturbations. Indeed, these may manifest as perturbations of the process of freely flowing associations. At the moment a perturbation occurs in the free flow, then a resistance is starting up and a defense can be reliably postulated as lying beneath the surface. Something has stirred in the unconscious that causes a disturbance to the ego; the ego's smooth-surface presentation cannot be maintained. The analyst watching these perturbations in the

process of the session must then decide what to do about his observations.

This is a moment when the classical approach diverges from the Kleinian one. The classical analyst says to himself, "Here is something the patient is touching on that his ego cannot at present cope with." The analyst must therefore be circumspect, lest he bring something out that challenges the patient's ego to such an extent that a more extreme defense is erected and the patient continues to hide this aspect of himself. The analyst must therefore work carefully, allowing things to come to the surface gradually at a pace the patient's ego can tolerate. Thus, at some point, the traumatic material will reach the preconscious; and the analyst, like a midwife, can deliver it in its last effort to reach the conscious surface.

Sensitive and sensible as this may sound, Kleinians take a radically different view, which sounds equally sensitive and sensible. In her clinical experience, Klein (1932) saw that the children who were most frightened were the ones who were most reassured by deep interpretations. She took as her parameter the degree of the child's inhibition, either in play or in the child's relationship with her. Klein found that if she made a deep interpretation to a more inhibited child—frequently, an interpretation of the Oedipus complex or the primal scene—the inhibition lessened.

Klein learned an enduring lesson from this practical, empirically verified experience.[4] In some sense, the functioning of the articulating analyst must have led to this effect. Thus, a three-step process was suggested to Klein as a way of gaining evidence for the accuracy of the interpretation, as follows:

(a) free association → (b) interpretation →
(c) post-interpretation material

Thus, if the interpretation is accurate, it will "work" by creating an appreciable change in the post-interpretation material and

[4] Despite Klein's lack of education as a scientist, natural or any other, she found herself supplying a setting for rigorous observation of cause-and-effect links in psychology. Interestingly, Ezriel (1957) pointed out that the process of interpretation and response in the patient is a here-and-now experiment that exactly mirrors experiments carried out in natural science.

affect. The distress of the patient is most sensitively addressed by grasping it as fully and confidently as possible. This sensitivity to the patient's need is quite different to what is seen in ego psychologists' approach; in fact, one could say that the ego psychologist is sensitive to the patient's conscious ego, while the Kleinian reacts sensitively to the patient's unconscious needs.

## PROCESS AND CONTAINMENT

The independent variable in this interpretive process is the articulating analyst. Increasingly, Kleinians have stressed that the analyst's mind plays a central part in the process of analyst–analysand interaction (Hargreaves and Varchevker 2004). The impact on the patient of an interpretation that articulates the depth of anxiety is a process, a here-and-now process; Money-Kyrle (1956) based his account of this on cycles of projection and introjection between two subjective intrapsychic worlds. Viewing that process takes the analyst a step away from a classical reconstruction of the patient's historical traumas and their distorting traces—even though the process that occurs here and now may have some connection with similar processes that occurred in the past.

By contrast, focusing on the here and now gives prominence to the patient's encounter with the analyst's mind, a mind that attempts to function psychoanalytically. Around the same time that Money-Kyrle elaborated his account of this process, Bion (1958) was also giving similar descriptions, this time from work with schizophrenic patients: "The implicit aim of psycho-analysis to pursue the truth at no matter what cost is felt to be synonymous with a claim to a capacity for containing the discarded, split-off aspects of other personalities while retaining a balanced outlook" (p. 145).

Or, more explicitly:

> When the patient strove to rid himself of fears of death which were felt to be too powerful for his personality to contain he split off his fears and put them into me, the idea apparently being that if they were allowed to repose

> there long enough they would undergo modification by my psyche and could then be safely introjected. [Bion 1959, p. 312]

This represents a process in which something of the patient is experienced by both parties as lodged in the analyst—at least temporarily—for a process of modification, before being returned to the patient. This particular modifying process is termed *containing*. It has become a foundation stone of the Kleinian theory of interpretation and treatment. The analyst's mind takes in a part of the patient or some part of the patient's experience, and modifies it by making it more tolerable. Bion made it clear that the modification occurs specifically to make the *something* intelligible; it is thus the Kleinian equivalent of insight. When things go well, as Money-Kyrle (1956) put it, the patient receives something back that was previously intolerable or incomprehensible, but has now been rendered more tolerable and meaningful. In addition, in the process of receiving that back, the patient (or the infant) receives something of the mind that did the modification. Thus, the patient gains an increment to his own mind—an increment that can in future give the patient a greater ability to articulate and modify that experience for himself.

Modifying disowned experience to make it tolerable first takes place as an action in the analyst's mind. In this sense, the Kleinian process means being much more involved in the patient's experience of his world and of himself: "A prerequisite of psychoanalytic treatment is that it is necessary to make enough contact with the patient's feelings and thoughts to feel and experience oneself what is going on in the patient" (Rosenfeld 1987, p. 12). In a way, the analyst has to become a little disturbed in order to really know the patient's disturbance. Yet, of course, this risks the analyst's becoming so disturbed as to lose his function as the analyst.

Brenman Pick (1985) investigated this projective process in some detail. The patient's unconscious seeks out a very specific part of the analyst into which to project—e.g., the analyst's critical superego, the analyst's sympathetic maternal concern—which can

then become mobilized as an enactment with the patient. This represents the mating of a specific part of the patient's mind with a specific part of the analyst's mind: "If there is a mouth that seeks a nipple as an inborn potential, there is, I believe, a psychological equivalent, i.e., a state of mind which seeks another state of mind" (Brenman Pick 1985, p. 157).

Money-Kyrle (1956), Bion (1962), and Segal (1975), as well as many others, all address the circumstance of an introjection by the analyst that creates a state of mind that the patient cannot cope with, and something other than the reprojection of a modified fear ensues.[5] The intolerable is something that blows the patient's mind—as it can blow a mother's mind or it can blow the analyst's mind. What *containing* refers to, then, is not so much the resolving of an intolerable conflict as the *repair of a mind.*

Increasing interest in Kleinian therapy represents a steady move from understanding conflict to understanding the way in which a mind fails to function and can disband itself. The analyst's process of containing is the performance of an ancillary function for the patient. He helps to put a mind together again so that it can subsequently begin to contain itself and its conflicts. There is a distinction here that was starkly expressed by Bion as the difference between a psychotic mind and a non-psychotic (or neurotic) mind. Bion's (1957) conclusions derived from experimental analyses he and his colleagues had undertaken with schizophrenics; consequently, the idea of a splintered, split-up mind came easily to them. Bion stated:

> The non-psychotic personality was concerned with a neurotic problem, that is to say a problem that centred on the resolution of a conflict of ideas and emotions to which the operation of the ego had given rise. But the psychotic personality was concerned with the problem of repair of the ego. [1957, p. 272]

[5] Bion (1962) says that the patient will reintroject *nameless dread,* which he and Segal (1975) describe in terms of a mother–infant failure wherein one of two scenarios occurs: either mother becomes rigid and dutiful, but does not allow in the intolerable thing projected by the infant; or mother does allow it in, but herself goes to pieces because it is intolerable.

Kleinian analysis has been profoundly changed by this work with schizophrenics, and Kleinian analysts tend to be especially attuned to disintegrative processes in the ego. Bion, like Klein (1946), thought the processes leading to disintegration were active ones. They lie *beneath* the more neurotic phenomena that psychoanalysis is usually concerned with: "Where the non-psychotic part of the personality resorts to repression . . . the psychotic part of the personality has attempted to rid itself of the apparatus on which the psyche depends to carry out the repressions" (Bion 1957, p. 270). This characteristic gives a particular distinctness to Kleinian psychoanalysis. It also gives another justification, in Kleinian eyes, to reach deeply into the mind of the patient, beneath the levels of repression and neurosis, in order to understand damage to the mind itself.

## THE GOOD UNDERSTANDING OBJECT

Klein herself thought that the ego forms itself on the basis of an introjection of a "good" object, a mother who provides good experiences, satisfaction, and love. The ego matures around this core of general internalized well-being and self-respect. The object introjected in analysis is a very specific good object, however; it is the good *understanding* object. It is introjected when the patient's intolerable mental entities have been modified by the analyst's understanding. The analyst's mind, in this small respect, is then internalized as the function of understanding this bit of experience. The patient's ego grows by that amount, and its capacity to have its own experience grows by that amount as well. Therapeutic action is thus the enhancement of the ego in its ability to contain its experience and tolerate its conflicts.

Bion formulated this very specific function as the *K-link,* where *K* represents knowledge. He thought of the analytic relationship as a link between analyst and analysand in which both seek knowledge of each other, with the ultimate aim being increased self-knowledge of the patient. The patient's knowledge of the analyst is necessary because he must know how the analyst's

mind works on the problem that he, the patient, found impossible and intolerable.

In contrast to the K-link, Bion postulated an *L-link* (*L* for loving each other) and an *H-link* (*H* for hating each other) between patient and analyst. Both the L-link and the H-link are distractions from the analysis. In extreme form, sexual boundary infractions are a manifestation of the L-link. Even minor forms of the analytic couple's cozying up to each other in supportive ways are also infractions of the analytic relationship. And one of the H-link's common manifestations is a sort of moralizing superiority.

For the analyst to eschew L and H is a stern doctrine; it is Bion's equivalent of the rule of abstinence. It is never possible to fully honor this injunction, and analysts sometimes slip from K, just as patients do. But in the Kleinian view, redemption from this sin takes the form of the use of a particular infraction to understand the nature of the core problem expressed in the transference. If this L- or H-link can be articulated in the analyst's mind and thus reprojected as a now-understood experience, then the patient can introject with it the understanding good object.

So the analyst's mind, and the relations it sets up, has become an important field of study in Kleinian work over the last two or three decades. Steiner (1993) has convincingly suggested that the function of the analyst's mind is so important to the patient that, for certain periods in certain analyses, interpretations must be *analyst centered;* that is, interpretations must focus on what the patient thinks, fears, and hopes is happening to the analyst's mind.

## DESTRUCTIVENESS AND SELF-DESTRUCTIVENESS

Early on, Klein noticed that children express high levels of anxiety, and that, from an early age, children are preoccupied with handling their own aggression toward others. She believed this was a kind of superego function. As Freud acknowledged, Klein was one of the more noteworthy analysts to describe an especially harsh form of the superego, particularly in young children (Freud

1930, p. 130n). Klein believed that this could be a manifestation of the death instinct. A great deal of debate has taken place over this question: is there a primary destructive and self-destructive element in the human psyche?

Klein's attempts to understand the schizophrenic patients of her colleagues and students led her to believe strongly that there was, indeed, a powerful self-destructive process going on in schizophrenia, which resulted in the splitting up and disintegration of the mind. Whatever the biological factors, this illness was experienced by the patient as a real self-destructive force, with real purposes and with real effects on his mind. The annihilation of parts of himself and their evacuation meant a real loss of knowledge of the self, often resulting in an enhancement of some state of mind or function in the analyst. Thus, the patient's loss is the analyst's "gain."[6]

Knowledge of the friable nature of the human mind that came to light as a result of schizophrenia research has been applied to other types of patients. In certain difficult patients, it is quite apparent that the ego splits, but it does so into coherent parts—unlike what occurs in schizophrenia, where splitting creates inchoate fragments. Currently, there is a good deal of research being conducted that aims at recognition of conditions in which the ego is organized in two parts—around a generally libidinal self and around a destructive self. This split in the ego represents a degree of de-fusing of the two instincts, libido and death instinct, resulting in a pathological organization (Rosenfeld 1971).[7]

This view of destructiveness is contentious. The idea that it is inherent as a need of some kind is anathema to some analysts who adhere to other traditions; they may consider aggression a justifiable reaction to an inclement external world. They argue that frustration, in all its forms, is all that is needed to explain human aggression, destruction, and self-destructiveness.

[6] This is an important phenomenon for the analyst to consider in sorting out his countertransference.

[7] Sometimes, a violent part of the ego fuses with elements of libido, and acts of exciting violence may result.

It is often difficult, in practice, to distinguish frustration from envy and primary destructiveness. For instance, in discussing a patient who felt that he was not listened to, Bion (1959) remarked that

> . . . associations . . . showed an increasing intensity of emotions in the patient. This originated in what he felt was my refusal to accept parts of his personality. Consequently, he strove to force them into me with increased desperation and violence. His behaviour, isolated from the context of analysis, might have appeared to be an expression of primary aggression. [p. 312]

This polemical argument has not been settled, and we often hear the view that Kleinian analysts can damage their patients by relentlessly interpreting a malign form of aggressiveness. It may be that Kleinians do not always consider the possibility of frustration as a source of destructiveness when making an interpretation; and, conversely, it must be said that other analysts may not always check the possibility of primary destructiveness as a source of aggression when formulating their interpretations.

In an analysis, it is now necessary to examine the transference-countertransference process for the possible presence of a to-and-fro dynamic—that is, at first the acquisition of knowledge and the transmitting of the good *understanding* object, and then the breakdown of that. In other words, the K-link may be engaged in for a while and then repudiated (an instance of what Bion called *minus-K*).

Joseph (1989) studied these movements in one direction and back again in great detail. The anti-life shift—away from the analytic relationship and away from analytic knowledge—is the Kleinian equivalent of the negative therapeutic reaction. Regular interpretation of destructive moments allows a constant but slow accumulation of understanding of the process, and, at the same time, incremental steps are made in building the patient's ability to spot these moments for himself. Insofar as these moments of knowledge might themselves be considered *pro-life,* interpretation could

be described as taking place on the side of libido and of ego integration. Insofar as these moments of the analyst's knowledge provoke envy or destructiveness, they also promote disintegration. This kind of technical management of knowledge creation has been under examination for many years (Hargreaves and Varchevker 2004).

## CONCLUSION

The therapeutic action that comes from interpreting deep-going destruction of knowledge and self-knowledge is that the analyst's mind can (in good conditions) "contain" the knowledge of this self-destructiveness. That kind of action is not easy for the analyst. It is hard, personal work to contain these states of mind, to articulate and re-present them to the patient, and to articulate and present them to colleagues. Wanton destructiveness is hard even to contemplate, and it is potentially demoralizing to confront on a daily basis. Indeed, perhaps the frequent repudiations of the Kleinian scheme have something to do with an understandable aversion to working with an intolerable and pervasive anti-life outlook.

### REFERENCES


Bion, W. R. (1957). Differentiation of the psychotic from the non-psychotic personalities. *Int. J. Psychoanal.,* 38:266-275.

——— (1958). On arrogance. *Int. J. Psychoanal.,* 39:144-146.

——— (1959). Attacks on linking. *Int. J. Psychoanal.,* 40:308-315.

——— (1962). *Learning from Experience.* London: Heinemann.

Brenman Pick, I. (1985). Working through in the countertransference. *Int. J. Psychoanal.,* 66:157-166.

Ezriel, H. (1957). Experimentation within the psychoanalytic setting. *Brit. J. Philosoph. Sci.,* 7:29-48.

Freud, S. (1905). Fragment of an analysis of a case of hysteria. *S. E.,* 7.

——— (1910). "Wild" psycho-analysis. *S. E.,* 11.

——— (1913). On beginning the treatment. *S. E.,* 12.

——— (1915-1917). Papers on metapsychology. *S. E.,* 14.

——— (1917). Mourning and melancholia. *S. E.,* 14.

——— (1921). *Group Psychology and the Analysis of the Ego. S. E.,* 18.

——— (1930). *Civilisation and Its Discontents. S. E.,* 21.

Hargreaves, E. & Varchevker, A., eds. (2004). *In Pursuit of Psychic Change.* London: Routledge.

Heimann, P. (1950). On countertransference. *Int. J. Psychoanal.,* 31:81-84.

Isaacs, S. (1948). On the nature and function of phantasy. *Int. J. Psychoanal.,* 29:73-97.

Joseph, B. (1989). *Psychic Equilibrium and Psychic Change.* London: Routledge.

Klein, M. (1932). *The Psychoanalysis of Children.* London: Hogarth.

——— (1946). Notes on some schizoid mechanisms. In *The Writings of Melanie Klein, Vol. 3.* London: Hogarth.

Money-Kyrle, R. (1956). Normal countertransference and some of its deviations. *Int. J. Psychoanal.,* 37:360-366.

Racker, H. (1968). *Transference and Countertransference.* London: Hogarth.

Rosenfeld, H. (1971). A clinical approach to the psychoanalytic theory of the life and death instincts: an investigation into the aggressive aspects of narcissism. *Int. J. Psychoanal.,* 52:169-178.

——— (1987). Impasse and interpretation. *New Library of Psychoanal.,* 1:1-318.

Segal, H. (1975). A psychoanalytic approach to the treatment of schizophrenia. In *Studies of Schizophrenia,* ed. M. Lader. Ashford, England: Headley Brothers.

Steiner, J. (1993). *Psychic Retreats.* London: Routledge.

Strachey, J. (1934). The nature of the therapeutic action of psycho-analysis. *Int. J. Psychoanal.,* 15:127-159.

Zetzel, E. (1956). Current concepts of transference. *Int. J. Psychoanal.,* 37:369-375.

---

*The Newling*
*373 Smeeth Road*
*Marshland St. James*
*Wisbech PE 14 8EP*
*United Kingdom*

*e-mail: bob@hinsh.freeserve.co.uk*

*Psychoanalytic Quarterly, LXXVI, 2007*

# THE MECHANISMS OF CURE IN PSYCHOANALYSIS

BY RÓMULO LANDER

*The author considers the theoretical contributions of Lacan and Bion in relation to therapeutic action or* the mechanisms of the cure. *Whereas Bion felt that the analysand should ultimately experience* transformation in O, *Lacan described the analysand's goal as* not to give in to one's desire *or* to be one's self. *The author distinguishes among various types of neurotic and psychotic structures in discussing the limits of the cure, noting that the analyst's* acts*—as well as his words—can function as analytic interpretations. Lacan's theories of* jouissance, *the* sexual phantom, *identification with the analytic function, and post-analytic effects are also discussed.*

## THE PURPOSE OF THE CURE

To discuss the theoretical problem of the mechanisms of cure demands that we first define the concept of *cure*. It is well known that many psychoanalysts avoid using the word *cure* in relation to their clinical practices; we do not say at the end of an analysis that the analysand is cured. Freud (1938) was himself not in favor of considering the cure an objective of the psychoanalytic method.

---

Rómulo Lander is a Training Analyst at Caracas Psychoanalytic Institute and a member of the Caracas Psychoanalytic Society, the Psychoanalytic Federation of Latin America (FEPAL), and the International Psychoanalytical Association.

However, the question of the purpose of psychoanalysis arises from time to time. In trying to respond to that question, I prefer to use the concepts that Bion and Lacan offered some time ago. For me, these two clever and creative analysts said the same thing, each in his own way. Bion (1965) tells us that the search for interior truth is essential for mental growth: "Without truth of one's self, the mind does not develop, it dies from starvation" (p. 38). For that reason, Bion concludes that the purpose of psychoanalysis is not symptomatic cure, nor is it the adaptation of the individual to the family or society. Rather, it is to help the analysand achieve what the individual really is: "to be what he is."

Lacan (1973) teaches us that the ethical position of the psychoanalyst relies on *speaking well* (*La éthique du bien-dire*). This *speaking well* merely indicates the road that will takes the analysand—on his own, as it were—toward the discovery of his internal truth. In this view, there is no imposition of meaning or values, no intention of suggestion, and no demand for adaptation, either placed upon or requested of the analysand by the analyst. Thus, Lacan confirms that the purpose of psychoanalysis is to help the subject "not to give in to his desire" and to "insist in his desire" (Lacan 1960, p. 314). Therefore, no demand is made for adaptation to family or society values; on the contrary, the purpose of analysis consists in helping the subject to be what he really is. It is clear that, to achieve this purpose, the subject should not give up his desire; however, Lacan adds, such an end result of the analysis is heroic, and "not to give up the desire" and "to be one's self" require big sacrifices that are not always within the analysand's reach.

On the other hand, Bion alerts us to the possibility of false results in analysis. He tells us that *to be what we are* requires a special transformation of the analysand, the so-called *transformation in O.* This should be distinguished from another kind of transformation described by Bion, one that, even though it has a certain value does not produce the desired effect of *being one's self.* This second type is called *transformation in K,* where K refers to *knowledge;* this is a transformation in which changes take place through an intellectualized analysis. It means achieving knowledge of one's

own infantile and oedipal history, but without achieving true change, without undergoing an emotional experience.

The transformation in O, referring to something unconscious beyond the repressed, produces a true change with a deep emotional experience. Very often, achieving a true transformation in O, or "insisting in the desire" and "being what we really are," clashes with the moral values of the family or society. For that reason, psychoanalysis, at its very foundation, is to be thought of as amoral. There are no morals that we are obliged to or supposed to impose upon the analysand. Psychoanalysis is based on its own ethics, which are those of the search for internal truth.

## THE LIMITS OF CURE

The wide variation that exists in the mental structures of analysands requires the application of certain variations in our technical approaches. It is not the same thing to analyze a neurotic structure as it is to analyze a psychotic structure. A neurotic structure—including neurotic narcissistic disturbances and borderline cases—is founded on the mechanism of repression (*Verdrangun*). This structure uses metonymy in its relationship with the Other (I am referring here to the Lacanian concept of the Other). This neurotic structure can tolerate lies, uncertainty, certain ambiguities of transference, and what the analysand might perceive as the analyst's rejection, without a mental collapse taking place in consequence. The capacities of the neurotic structure allow the unfolding and the operation of transference in a typical cure, also called a *standard cure,* in which analytic neutrality, free-floating attention, the silence of the analyst, and familiar forms of analytic interpretation are the basic tools that the analyst has at his disposal in conducting the analysis.

The compensated psychotic structure (or so-called *stabilized psychotic structure*), one without visible psychotic manifestations, does not tolerate anything that resembles a rejection, since such an experience may trigger a mental collapse. This structure does not have the resource of metonymy available, leaving little space

for the analyst to function; the analysis will then be limited to the analysand's tolerance of only a rigid transference. This forces the analyst to be very careful about what he says and does in sessions.

In these latter cases, the main tool that the analyst has at his disposal is something we might call *pedagogic activity*. That is to say, the analysis becomes one directed toward the ego, where the aim is to teach the analysand to survive. This type of help is sometimes lifesaving, and may offer the possibility of reordering the subject's life. Sometimes that is all we can aspire to. In my clinical experience, enough reasons exist for the analyst to be satisfied with these analyses and their favorable epilogues.

On the other hand, when we are confronted with what we might call the "clinical syndrome of the hole"—rather than with a symptomatic picture characteristic of a neurotic conflict, or of the residue of a neurotic trauma—and when this "interior hole" or narcissistic deficiency of the analysand is of such a magnitude that the transference bond with the analyst becomes fundamentally necessary for the psychic integrity of the analysand to be maintained, then we find that the analysis can become understandably (and, we may add, rightfully) endless. This type of analysand is capable of reordering his system of ideals and may actualize them, producing important changes in his mental structure and improving his quality of life. Also, this analysand can rescue his traumatic memories of childhood from repression and can come to know something about his repressed infantile sexuality, but the "interior hole" itself does not undergo any modification.

These patients require a permanent form of a transferential presence of the analyst's figure (or, perhaps, a substitute transferential structure instead, such as a new subject-idol in a religion or sect). Although a substitute structure may be acquired, or an analyst-inspired change may occur, such an analysis is apt to continue endlessly.

## MECHANISMS OF THE CURE

After much consideration, I have come to the conclusion that we can reduce to only two the fundamental mechanisms that play a role

in the analysand's transformation: (a) insight (self-knowledge), and (b) reliving (emotional experience).

*Insight* refers to the capacity of the analysand to know what he has previously not known about, or has preferred to ignore, about himself. That is to say, something about himself is made conscious to the analysand that until then was not known or consciously acknowledged. In the process of analysis, this is achieved through the use of language. But sometimes, when words alone fail, it is achieved only through an act. Here we must ask the following question: the word (*parole*) and the act of whom?

The quickest, most simple answer turns out to be an inexact one: *the word and the act of the analyst.* This is—and, at the same time, is not—certain. The analyst has one fundamental tool: psychoanalytic interpretation. He believes that he interprets, but, we may ask, is this really the case?

Permit me to raise the question of who really interprets in analysis? The analyst in his verbal utterances proposes an idea to the analysand. Let us suppose that the idea is fresh, spontaneous, new to the analysand, and that it points to his unconscious. The analysand listens. One might say that the comments of the analyst have gone through (crossed) the self of the analysand, entered his subjectivity, and have produced an effect. The nature of that effect depends on what the analysand has understood from the analyst's remarks.

We could then rightfully say that the analysand builds his own new interpretation, starting from what he heard from the analyst. In the end, the effective interpretation is actually the one that the analysand has built. For that reason, the question of who interprets must be taken seriously. The objective of the analyst's intervention is to produce an effect of a signifier through the word (*parole*). A knot, a bond, is achieved between the one who emits the word and the one who receives it.

Lacan said that knowledge alone speaks (i.e., it speaks alone; knowledge speaks by itself). In his view, the analyst emits a statement (*énoncé*) that carries with it a latent content, which Lacan called *enunciation* (*énunciation*), which is something that goes

beyond the word itself. This opens up the opportunity for the analysand, through enunciation, to build his own interpretation and to find in it his own sense and meaning.

Regarding the *act*, we might note that the analyst's word (*parole*) sometimes fades. The word itself has become ineffective. The analyst's stated interpretation gets lost in nothingness. It may happen, then, that the analyst's *act* proceeds, as an alternative to the word, in order to make some sense according to the terms of the analysand's subjectivity; in fact, this act may have the same effect as an interpretation.

Here we venture into forbidden territory. It is common to observe in supervision an analyst-trainee who suffers from feelings of guilt because he has carried out an act without conscious intent—that is to say, a true instance of *acting out*. When examining the situation (a posteriori in supervision), we often find that the analyst's acting out had a reason behind it, and thus led to a favorable effect in that particular case.

The second basic mechanism in achieving the analysand's transformation, that of *reliving* (emotional experience), refers to the presence of affects and emotions in the analytic process. Many contemporary analysts, in all three geographical regions of the International Psychoanalytical Association, agree on the importance of this aspect. Winnicott (1955) outlined the importance of working with regression during the analytic session, and he concluded that it occurs in the service of analytic progress. This regression will allow and facilitate an emotional experience to take place. The silence of the analyst and the interpretation of certain aspects of an infantile transference allow and facilitate regression, thus promoting intense emotional experience within the session. Such regression and the consequent emotional experience (reliving) open up the possibility for transformation into O.

In this way, the analyst's intervention cannot be thought of as merely an intellectual one. Intellectualization limits the possibility of producing a deep psychic change. True emotional experience intensifies the reliving experience. For that reason, regression in the service of the ego is welcome, and is necessary in order to make

it possible for certain psychic changes in the existing psychic structure to take place. The transference interpretations of preverbal, pregenital aspects, which we may think of as belonging to Lacan's *imaginary order,* intensify the regression and the emotional experience. These interpretations of archaic transference elements, connected to the imaginary (narcissistic) relationship with the other, give greater value to transference interpretation—as contrasted with automatic interpretation of transference, which may produce merely a banal, essentially ineffective form of work with the transference.

I am among those analysts who think that the basic clinical psychic structures (neuroses, psychoses, and perversions) are those that, once established in early childhood, cannot be changed into one of the other structural forms. Inside each structure, transformations and necessary psychic changes will allow a personal realization to occur, as well as allowing for the possibility that the subject may arrive at whoever he "really is." For example, a psychotic structure, based on the absence of early psychic mechanisms—such as the absence of an operative symbolic order, with its consequence of leading to great difficulty in establishing a social knot (or bond) because of the foreclosure (*forclusion*) of the Name of the Father (paternal function)—can never become a neurotic structure, which is based in the mechanism of repression (*Verdrangun*), since the latter already has the inscription of the paternal function.

However, through analysis, the psychotic structure may reach a new psychic balance—called *compensated* or *stabilized* psychotic structure—and end up achieving some kind of inner harmony. According to the Lacanian view, this can be accomplished with the acquisition of a new psychotic symptom (a fourth knot, also called a *sinthome*) that ties together the three basic orders (the Real, the Symbolic, and the Imaginary—RSI). In this way, a stable psychotic structure will become capable of supporting a functional mind and working at the level of a (functional) social knot (unfortunately, without the use of metonymy, however). In this way, the stabilized psychotic has found a useful way of living in the world. Even though it is stabilized and functioning, and is free of disordered

clinical manifestations, this structure will continue being psychotic; it cannot be otherwise, according to Lacan. The absent early mechanism of the Father's name (foreclosure) means that the psychosis is not amenable to change.

## FOUR ADDITIONAL ASPECTS OF THE MECHANISMS OF THE CURE

### *The Theory of* Jouissance

The theory of *jouissance* in psychoanalysis constitutes an original Lacanian contribution (Lacan 1960).[1] To my knowledge, this theory offers something unique to our understanding of human suffering.

The concept of *jouissance* refers to something that is beyond the pleasure principle. It is an implicit opposition between *enjoyment* (*genub*) and *pleasure* (lust). It is something that connotes suffering beyond the pleasure. It is not a symptom and it is not a phantom. Each subject possesses his obligatory amount of *jouissance* for the maintenance of his psychic balance, and the particular magnitude of *jouissance* varies according to each subject. Why do some subjects need a different amount of *jouissance* than others in order to maintain psychic balance? Neither Lacan's answer to this question nor that of the post-Lacanian group is very clear. For me, the puzzle of what amount of *jouissance* is necessary for each individual subject must have multiple answers. One of the determinants is the (arbitrary) amount of suffering that was present in the early infant's life during the time of formation of the psychic constitution.

I consider it useful to differentiate the theory of Freudian moral masochism, the theory of repetition compulsion, and the theory of anxiety from the Lacanian contribution of *jouissance*. First, let us remember that Freudian moral masochism also refers to a particular form of human suffering. However, in moral maso-

[1] In Spanish, we say *goce* instead of *jouissance,* but English has no good translation of the word, so the French original is retained.

chism, the suffering is a consequence of the demands of the Freudian superego or of its Kleinian equivalent. Moral masochism follows from the application of unconscious guilt feelings. The suffering caused by moral masochism leads to a relief of guilt feelings. During the analytic cure, one of the symptoms that disappears or improves is, in fact, the tendency of the subject to use methods of self-punishment to alleviate unconscious guilt (which is based on fantasies). It is necessary to distinguish this masochistic suffering from the suffering produced by *jouissance; jouissance* itself is not a symptom and will not disappear.

Second, I have sometimes observed the tendency of certain patients to repeat behaviors that lead to suffering; this constitutes a way to provide the amount of *jouissance* necessary to maintain the individual's psychic balance. To explain this repetition of particular behaviors by means of the theory of the repetition compulsion, according to my understanding, would be a conceptual error; the repetition compulsion concept, by contrast, is related to the death drive and is connected to the theory of the Automathon (Lacan 1964).

Third, it is necessary to distinguish the presence of anxiety from the presence of *jouissance* in the subject. Anxiety (bound or floating) can be seen as a symptom. It is a nuisance and a form of suffering, the product of psychic conflict. Anxiety, when considered from this phenomenological point of view, is conceptually different from the suffering caused by *jouissance*.

The necessary amount of *jouissance* that each subject needs in order to maintain his mental balance depends, therefore, on his infantile history. It is something embedded in his psychic structure and is thus part of that structure. It is not something that can be removed. It is something authentic to each subject, and each person has to learn how to live with it.

### *Theory of the Phantom*

The theory of the *sexual phantom* (*La logique du fantasme* [Lacan 1967]) is significant for the way in which the analyst will un-

derstand and work with the sexual and erotic life of the analysand. A hundred years ago, at the beginning stage of psychoanalysis, the idea that there might be several variations in basic models of sexual life was not easily accepted. At that time, the attempt to distinguish normal from pathological sexual behavior led to serious discrepancies and problems. Today, in spite of all the progress in science and awareness of cultural influences, within some psychoanalytic circles we still find the presence of moralistic attitudes in relation to sexual life. When we participate in clinical presentations, we may at times encounter resistance in certain of our colleagues to an acceptance of the legitimacy of particular variations of sexual life. Some prefer to label these variations as pathological sexual behaviors, which may, in fact, fall within the overarching concept of the *sexual phantom.*

The concept of the *phantom* (*fantasme*) was introduced into psychoanalytic theory by Lacan (1967). It corresponds, approximately, to a sexual fantasy with images and a miniscript, created by the subject in early childhood. Lacan said that this phantom is always sexual, and also always perverse (because its intent is to conceal or deny the subject's castration). He frequently called it *the treasure of sexuality*. Each subject builds his own sexual phantom during early childhood, and because of the phantom's perverse nature, it is often repressed at the beginning of analysis. As analysis progresses and the ideals and censorship of the subject are modified, the phantom becomes an active part of his sexual life.

If the analyst considers these perverse sexual fantasies to be pathological, he will treat them as neurotic symptoms and will try to interpret their meaning in the hope that the sexual phantom will disappear. If, on the contrary, the analyst considers that this perverse sexual fantasy is a *treasure of sexuality,* he will not treat it as a symptom, and does not think it requires interpretation. The analysand learns about his phantom and how to enjoy it.

It is evident that these are very different ways of treating this aspect of the subject's sexual life. According to the analyst's theory, the sexual phantom will be approached in a different way, with different consequences.

*The Problem of Identification with the Analyst in the Cure*

First of all, is identification with the analyst a healing factor in the process? And, second, can we distinguish *identification with the analyst* from *identification with the analytic function?*

The goal of identification with the analytic function is based on the belief that this identification facilitates the capacity of the analysand to achieve insight. I agree with this idea, and I am of the opinion that it is unavoidable that the analysand identifies with diverse signifiers originating in the analyst in the course of pursuing an analytic cure.

Let us not forget that the patient becomes an analysand only when he discovers that he wants to know more about himself, thus developing his own interest in a capacity for introspection, rather than simply requesting answers from his analyst. This is the point when the analysand becomes truly open to the possibility of discovering unconscious contents. In the beginning, this knowledge is seen as the exclusive property of the analyst. For that reason, the patient initially searches and chooses a particular analyst, who, by virtue of transference, is regarded as the owner of all wisdom. This view of the analyst is described by Lacan as the *subject supposed to know*—*SSK* (*sujet suppose savoir*—SSS). This SSS is an unavoidable phenomenon of the Imaginary order (we may call it narcissistic).

In theory, at the end of the analysis, the image of the wise (phallic) analyst collapses totally, and the analyst appears in the transference as castrated—that is to say, devalued—rather than as an omnipotent phallic figure. Bion said that the analyst's final destination, at the end of the analysis, is precisely to become devalued and useless. The analysand accepts both his analyst's castration (that is, his de-idealized status) and his own equally incomplete state.[2]

[2] We might note here that, with respect to the end of the analysis, Bion's and Lacan's viewpoints coincide. Neither considers that the analytic end occurs when the analysand finally identifies with the idealized analyst; on the contrary, that phenomenon is more descriptive of the situation at the beginning of analysis.

Despite all this, during the analytic cure, the analysand will identify with certain signifiers coming from the analyst—for example, those signifiers seen as originating in the ideal analyst, which the analysand has come to understand through and from the analyst's interpretations. This will produce certain changes in the operation of the superego of the analysand. These changes in the superego will open the road to the acquisition of insight—or, at least, an increased capacity for the acquisition of insight—on the part of the analysand. This phenomenon closely resembles Kleinian (and other) analysts' conceptualizations of identification with the analytic function.

Something very different happens with the mechanism of identification with the analyst, in which otherness is lost, as well as the capacity to discriminate and the asymmetrical relationship with the other. Identification with the analyst, as a mechanism of cure, is fragile and cannot be sustained permanently. It can be thought of as a kind of transference cure. However, the effect of this transference cure is surprising and dramatic, similar to those that can take place under the influence of hypnosis. I repeat my belief that they are not sustained over time, however, because they are artificial, and they do not correspond to a discovery of inner truth and a resulting genuine internal change.

Lacan contends that the analyst and the analysand establish an asymmetrical relationship that leads to and creates the possibility of an analytic act. This does not mean that, during the cure, other (symmetrical) moments that are not considered analytic do not also occur; in fact, this does take place during pedagogic moments or moments of support, which I prefer to call *orthopedic*.

### *Post-Analytic Effects*

Post-analytic effects in the cure will either be considered important or irrelevant, depending on the analyst's theory. The concept of these post-analytic effects becomes complicated when the discussion arises of the difference between an *interrupted analysis* and a *terminated analysis*. Such a discussion obliges us to specify what

we mean by the theoretical concept of the *end of the analysis.* In defining the termination of analysis, we all know that it is not possible to be guided simply by symptomatic cure—or, for that matter, by the fulfillment of the capacity for work and joy, as Freud said. In brief, structural theory today outlines that the theoretical end of analysis occurs when the subject accepts *being what he is,* has encountered and accepted his *sexual phantom,* and has also accepted his limitations and incompleteness.

Post-analytic effects are connected to the ultimate fate of the transference. In the transference, at the theoretical end of the analysis, the analyst no longer occupies the place of the *subject supposed to know*—SSK—and appears instead as a limited and incomplete subject. We might say that, at the end of the analysis, the analysand has accepted his own symbolic and imaginary castration. He also identifies with his own *sinthome* (Lacan 1976). I prefer to say that the analysand accepts his *fundamental phantom,* different from the *sexual phantom.* This means that the subject accepts (without conflict or guilt feelings) the indelible marks of childhood that have resulted in the formation of his character.

Such an achievement is possible when, during the course of the analysis, the subject has modified his system of ideals. Theoretical discussions about the end of the analysis must be reconciled with the implicit variability suggested by the case-by-case rule, in terms of the measure of post-analytic effects.

## REFERENCES


Bion, W. R. (1965). *Seven Servants.* New York: Aronson, 1977.

Freud, S. (1938). *An Outline of Psycho-Analysis. S. E.,* 23.

Lacan, J. (1960). *The Ethics of Psychoanalysis: The Seminar, Book VII.* London: Routledge.

——— (1964). Tyche and Automathon. In *Four Fundamental Concepts of Psychoanalysis: The Seminar, Book XI.* London: Routledge, 1971.

——— (1967). Logic of the phantom. Mimeograph version, livre XIV.

——— (1973). L'étourdit. *Scilicet,* 4:5-52.

——— (1976). Le sinthome. Mimeograph version, livre XXIII.

Winnicott, D. W. (1955). Psychological and clinical aspects of regression within the psycho-analytical set-up. *Int. J. Psychoanal.,* 36:16-26.

*Avenida Venezuela*
*Policlinica Americana*
*Consultorio 4-D, Urb. El Rosal*
*1060 Caracas, Venezuela*

*e-mail: ralander@viptel.com*

*Psychoanalytic Quarterly, LXXVI, 2007*

# THERAPEUTIC ACTION IN SELF PSYCHOLOGY

BY KENNETH NEWMAN

*The author summarizes Kohut's principal theories and their implications for understanding therapeutic action. He notes that Kohut's model of self development can be applied to both healthy and pathological outcomes, and that this model necessitates modifications in classical psychoanalytic technique. A discussion of some of the many variations within self psychology includes elaborations of Kohut's beliefs that have been contributed by more recent theorists. The author also discusses the centrality of affects in the formation of psychic structure and the implications for technique of this theoretical construct.*

## INTRODUCTION

Kohut's (1971) theory, which placed disturbances in the development of the self as central to the formation of pathology, evolved gradually from his clinical practice. What became clear to him was that many of his patients (and those of his supervisees), heretofore understood from a drive-defense model, were communicating pathological character structures through their symptoms and, most especially, through their unique transference presentations, which were the result of environmental traumata that related to issues involving the establishment of a cohesive self. When Kohut

Kenneth Newman is a Training and Supervising Analyst at the Chicago Institute for Psychoanalysis.

began to look at his patient's symptomatic complaints, compromised relatedness, and vulnerability to fragmentation anxiety from the perspective of a self disturbance, he came to recognize the importance of the early environmental caretakers, whom he called *self-objects.*

The term *selfobjects* is meant to describe persons in the external world who are experienced psychologically as a required part of our selves. Selfobjects are needed throughout life, and the functions they serve change with shifting developmental demands. While they continue to be important at all times, when they appear more noisily or as part of a "hunger," we may say they represent the need for a set of functions (idealizing, mirroring, twinship) that was not acquired in early life. By locating the pathognomonic point of fixation at a time when the child's self and its relationship to selfobjects is primary, Kohut could argue that the failures in these bonds lead to arrests in development that would emerge in treatment as psychological needs, not simply residual infantile wishes. In other words, the major disturbances occurred at a time when selfobjects would be crucial in establishing self cohesion, self enhancement, and validation. Remediation in analysis includes mobilization and reactivation of those selfobject transferences that continued to be necessary for internal reorganization and structure building.

Like Winnicott (1965, 1971), Balint (1968), and others, but in a more systematic way, Kohut saw that patients whose traumatic development resulted from the empathic failures of parental figures would require the clinical situation to provide new opportunities to reconnect with the analyst as selfobject, in order to reactivate derailed developmental processes and correct a frozen or split-off emotional life. Since the locus of pathology was shifted from infantile drives in conflict with a critical superego-ego system to developmental failure, the patient's inability to outgrow the need for objects was seen from a different perspective. In short, if the original foundations of a cohesive self were still in flux, then the search for the objects (in however distorted a way this was manifested) to complete the self was seen as related to legitimate needs.

However inappropriately archaic the character pathology, symptomatic expressions, and ways of relating to others and themselves might seem, these factors reflect and express developmental needs and thwarted strivings whose therapy require a new kind of emotional experience. Ultimately, the hope is that this can occur through finding a "usable object" as mediated in the transference by the analyst.

*Usability* (Winnicott 1965, 1971) refers to an achievement in object relations that represents the subject's ability to place the object outside the realm of omnipotent or selfobject control. It denotes a capacity for a relationship that can allow for some separateness of the other. It has a point of confluence with all psychoanalytic models in that it implies that the subject does not experience or necessarily require the other for defensive purposes. The major yield of reaching usability is that the object (selfobject) is now available for new emotional exchanges, structure building, and the opportunity to analytically rework old transferences.

## KOHUT'S MODEL: HEALTHY AND PATHOLOGICAL OUTCOMES

Kohut's model of the developmental stage of self formation, aided by experiences with needed selfobjects, aims to describe healthy as well as pathological outcomes. He emphasizes the role of parental caretakers as crucial in facilitating cohesion and self enhancement, leading to higher levels of integration as the selfobject function becomes internalized. If, however, the environmental parents are inadequate to the task, the process of internalization will be faulty, and significant fixations will occur. These will be manifested in an intensified and often pathological search for objects to complete the self. This prolonged need, as well as characterological defenses against it, will appear in the complex narcissistic configurations emerging in the analytic situation.

Kohut originally stated that, under optimal conditions, the exhibitionism and grandiosity that are phase appropriate for the infant self gradually become modulated and integrated, fueling ego

syntonic ambitions and aims and serving as a continued source of self-esteem. Similarly, the idealized parental imago will undergo transformations (including expectable disillusionment) and become a vital component of the psychic structure, serving as a guiding ideal and a source of internal validation of meaningful activities.

But if the child suffers severe narcissistic traumata, then the grandiose self remains in a fixated, unaltered form, walled-off or split-off, in continual need ("hunger") of responsiveness. Similarly, if the child experiences too great a disappointment in the idealized parent (either as an early self-model for tension and affect regulation, or later as the bearer of admired standards), this configuration will fail to become seamlessly integrated into the self as a tension-regulating and ego-guiding structure. It will remain in an archaic form. The result of these failures is that the child seeks restitutive means to maintain homeostasis, often assuming addictive forms of drives, or perversions, or delinquency, to effect comfort or self-esteem regulation. Additionally, the child may form pathological bonds of attachment, which serve to compensate for the lack of wholesome and "usable" ties. While the injured child employs a variety of ways (often forged from innate talents and abilities) to protect the vulnerable, anxiety-prone self, the deep-seated yearning for selfobjects to aid him in rehabilitating a developmentally derailed self, and reconnecting with split-off or unintegrated affects, continues unabated.

## HOW KOHUT'S MODEL EFFECTS A CHANGE IN THE PSYCHOANALYTIC SITUATION

By positing the point of pathognomonic fixation at a stage in development prior to the consolidation of the self, Kohut legitimized the patient's claims, however disguised, for responsiveness. Emphasizing that, as analysts, we are being deployed in the transference to fill in uncompleted psychological structure and to validate the significance of emotional requirements relieves us from

taking a role that patients can experience as adversarial. We become focused on illuminating and accessing the patient's needs, rather than on discovering and interpreting hidden and "illegitimate" infantile wishes.

A further extension of the shift away from the experientially adversarial position is seen in the attitude toward "resistance." Like Winnicott, Kohut reconceptualized what had been deemed *resistance*—formerly thought of as the patient's attempt to evade the superego, or even to defeat the analyst—as instead constituting a response to impingements or empathic failures on the part of the analyst. Kohut further elaborated this when he observed that his patients' regressive expression of archaic self states was based on ruptures in the self-selfobject transference, rather than on intrapsychic defensive operations designed to ward off deeper analytic involvement. This meant that the analytic focus shifted to understanding the causes of disruption, both in the context of their genetic roots and in empathic breaks in the analytic situation.

However, the most dramatic change in the analytic climate emerged from Kohut's construction of transferences, now seen as carriers of needs linked to fixations caused by environmental trauma. These narcissistic configurations, as they became elaborated, appeared as admixtures in a rigidified form of the original needs, as well as the adaptive/maladaptive defensive solutions.

Kohut described several major forms of selfobject transferences. The broadest of these relates to the grandiose self, with its complementary selfobject needs as they pertain to distinct variations that include the mirroring, the alter-ego, and the twinship selfobject. We also have needs for idealized selfobjects. The requirement for this parental selfobject begins with mother's earliest function as an omnipotent figure capable of aiding the infant with tension and affect regulation. It continues as part of the spectrum emerging in later developmental stages, where the idealizing object provides paradigms for the fulfilling of ideals and ambitions.

While Kohut offered a differential classification of these narcissistic transferences, it is clear that such sharp demarcations

may not always occur. Further, it should be noted that the establishment of these self-selfobject transferences in the analytic situation usually points to the fact that earlier editions of these needs were frustrated and therefore have become intensified. Often, the appearance of these needs in the external world—usually in some split-off or derivative (or symptomatic) form—will be considered an expression of selfobject hunger. Thus, as we encounter a form of the mirror transference in treatment, we will surmise that, as a result of insufficient early responsiveness, the patient will deploy into the analysis the yearning for confirmation and acceptance. Similarly, alter-ego or twinship transferences may appear. These manifest as seeking a selfobject who conforms to the self in appearance, values, or opinions, in order to provide a confirming reality and validation for the existence of the self.

One further point Kohut made was that all these transferences, when established in analysis, were anchored in and emerged from a solid core of repressed need. He meant to distinguish between fleeting manifestations and those more abiding, analyzable configurations representing specific self-selfobject transferences.

It is also important to distinguish between archaic narcissistic presentations that represent the way the self has attempted solutions or defensive restitutions, and the emergence of an expanded grandiosity that can be liberated from behind a wall of repression in the analytic situation. For example, Citizen Kane as portrayed by Orson Welles is a study of a restitutive position forged out of early trauma that, while a derivative of the original need for mirroring and confirming, represents grandiosity in its more archaic and defensive form. In treatment, the aim would be to address the needs of the child, linked associatively to the sled, the "Rosebud" image, and the deeper, theretofore walled-off needs for an insufficiently mirrored self.

Of greatest importance is the analyst's awareness that these "transferences," while they might express defenses against retraumatization, are for the most part the leading edge of or expressions of narcissistic needs. This Kohutian perspective was quite different from the prevailing school of thought (as illustrated by Kernberg [1974]), which viewed narcissistic presentations as a de-

fense erected to protect against conflict with "bad" internal objects.

For Kohut, the task of the analyst is to accept these narcissistic transferences and allow them to unfold—not to challenge them as defenses against primitive drive-superego conflicts. For the analyst, an additional problem is how to manage his own countertransference in the face of so little evidence of "traditional" libidinal transferences. The analyst's appreciation of the possibility that these presentations are carriers of need for missing developmental experiences makes a great deal of difference in his attitude toward his patients.

## THERAPEUTIC ACTION

Kohut's view of the essential aspects in the psychoanalytic cure of patients with analyzable narcissistic disorders centers around the accretion of structure via optimal frustration of the analysand's needs, aided by an empathic surround and mediated through the analyst's optimal use of interpretation. This can be maximally achieved through a two-step process that begins with an understanding phase and is then followed by an explanatory stage.

The first stage involves the analyst's grasping and communicating to the patient his understanding of the core of the patient's subjective states. This will include acknowledging recognition of the needs embedded in the patient's associations, dreams, and so forth. For example, fairly early in the work with a 40-year-old woman who suffered from bouts of lethargy and depression, as well as an inability to work effectively, the following dream occurred. She has finished school but feels there are crucial courses she has missed; she is back at a school trying to find the right teacher to help her complete a particular course. The analyst interpreted that the patient sensed that certain psychological needs had never been fully met, hampering her in acquiring necessary emotional skills. The analyst wondered if the dream reflected a hope that, with the help of the analyst, these missing experiences could be revisited and hopefully relived in a more useful way.

Of course, this dream could have been interpreted with a different emphasis. The sense that the patient had not accomplished enough could be an internal criticism coming from a critical superego, or the focus might be on the failure of her teachers (parents), and represent a harbinger of specific negative transferences. But in this instance, the analyst addressed the patient's sense that there was something she had not internalized, something missing, which spoke to a developmental arrest and the need for psychological assistance. The analyst inferred also that this need would become linked to the transference. The patient responded warmly to this interpretive line and brought into the analysis further evidence to support the relative accuracy of the analyst's response. Thus, as an analysis proceeds and transferences become more consolidated, the analyst's response will include legitimizing the patient's distress upon the reactivation of old unfulfilled needs and temporary failures, or upon inevitable breaks in empathy within the current transference.

Kohut spoke of structure building within the context of optimal frustration. Later, other self psychologists (e.g., Bacal [1985]) would challenge this tenet, but Kohut explained his position as follows: The analyst frustrates in that the emerging needs are identified but not acted upon. It is an "optimal" frustration because he offers the patient an empathic surround through an attitude of acceptance and confirmation of the legitimacy of these mobilized needs. It is also considered optimal because the attuned understanding enhances the development of an empathic bond, which facilitates strengthening of a cohesive self and expands the capacity for an analytic alliance.

The second step (note that this two-step process is usually not so well demarcated) includes well-designed verbal interpretations that identify more accurately the nature of the unfolding transferences and the patient's psychological reactions to them. This will lead to deepening insight into the meaning of the current transferences and their genetic antecedents.

Of even greater significance in the evolution of the self psychological theory of curative action are explanations that take up the

process of disruption and repair within the analytic self-selfobject bond. Through the provision of an empathic milieu, a greater sense of safety is created in the context of a rising expectation that selfobject needs will be heard and accepted. Within this context, the specific transferences associated with earlier repressed or split-off needs can be revived and illuminated. As part of this process, transference disruptions will occur as a result of both inevitable circumstances (e.g., weekend breaks or vacations) and relative "failures" in empathy. Through the analyst's appropriate responsiveness, the impact and meanings of these disruptions can be identified and linked to both the current state of the transference and to genetic antecedents.

Again, the analyst's major tool is the use of insight in order to increase depth of understanding and help give a sense of conviction to the patient. Kohut saw this particular interpretive activity as contributing further to the strengthening of the self, but also as a phase in what he called *transmuting internalization*. The repeated process whereby the patient's current injury is understood as embedded in the continuing need for selfobjects, now frustrated by a break with the analyst, provides an opportunity for the patient not only to feel a sense of repair, but to gradually internalize this experience. In this manner, patients can begin to help themselves as they take over the analyst's function.

While Kohut saw the work with disruption and repair as part of the analytic process, later writers, like Wolf (1988), take this up in a more detailed way. His explanation for the curative action begins to refer to affect integration. Wolf's emphasis on affect management and integration, as mediated by the analysis of rupture and repair, is a paradigm for addressing what I consider to be a second dimension of selfobject need. While Wolf seems to be describing a holding-function activity, intensified by inevitable "breaks" in the treatment, the analyst's capacity to bear the heightened affect states in fact addresses a need of the patient theretofore often unmet. Just as being available for the deployment of narcissistic transferences in the sphere of mirroring and idealizing needs is essential, the patient also requires a selfobject to help regulate unmanageable affect states.

I will develop this theme of the second dimension of need and deficit in the succeeding sections.

## CONTEMPORARY ISSUES

There have been criticisms of Kohut's model not only from the earliest days of its introduction by classical theorists, but, more recently, by relationists and social constructivists. Self theory has often been criticized for, among other shortcomings, lacking a theory of conflict, and for minimizing the central role of drives. While self psychology has not been alone in changing our attitudes toward character pathology and resistance, it has certainly played an important role in modifying current perspectives. Placing the central disturbance at the time of the formation of the self, coinciding with the child's need to reorganize its relationship to its objects and contain anxiety, gives a particular cast to the resulting character pathology. Symptoms, drive expressions, and significant deformations and compromises in relating are seen as serving overdetermined motives, including functioning as protections against the dangers of retraumatization.

Further, within the treatment process itself, shifts in the patient's associations, mood states, or connection to the analyst are viewed as predominantly responses to disruptions in the transference, caused by breaks in empathy. In addition, character pathology, with all its multifaceted forms of presentation, is seen as the *potential carrier,* the forward edge (Tolpin 1971) of developmental needs.

With these ways of viewing the patient, there is much less stress on defensive evasions. Originally, the emphasis that self psychology placed on character as conveying what is needed, rather than what is concealed, placed it in opposition to the traditional model. Thus, when self psychology was first presented, classical analysts decried the inattention to defense analysis, and self psychologists characterized the former as creating an adversarial atmosphere.

Recently, this polarization seems to be thawing. A number of self psychologists have viewed the apparent minimization of the

role of defense analysis as a problem that stands in need of revision. Examined more closely, the theory has always recognized the patient's conflicts as not connected primarily to anxiety about infantile drives, but, instead, as emerging from a fear of being retraumatized by unresponsive selfobjects. Thus, while the patient may crave selfobject experiences, he is fearful that his needs will be rebuffed and that he will reengage the memories of early disappointment and associated unruly affects that have never been integrated.

In fact, as the patient enters the analytic situation, a conflict is immediately mobilized. The needs linked to repressed narcissistic strivings are activated, along with the memory of faulty responses. But a further problem implicit in the model is that the affect states associated with failures in the mirroring and idealizing needs will also be aroused, and the psyche will lack the structure to deal with them. When affects are given a more central position in the creation of pathological character, the patient's motives for remaining attached to old solutions, as well as the conflict over establishing new attachments, become clearer.

Schafer (1983) offers a post-ego psychological perspective that also decreases polarization among models. As Aron (1996) points out, Schafer considers resistance in terms of what it is for, rather than what it is against. He suggests that the pejorative view of resistance often linked to the classical tradition did encourage adversarial positions; however, overall, there is now more agreement that "resistances" must be viewed within the total analytic situation. Contemporary analysts from every model consider the emergence of "resistances" as multidetermined and, at times, as communications signaling a break in the analytic tie or a failure of empathy. While many analysts practice a so-called one-person psychology, nearly all accept the importance of interactional processes and the notion that unconscious communications can be bidirectional, influencing and shaping current transferences and countertransferences. This emphasis on the interactional component and the importance of countertransference adds an expanded and more

compassionate view of resistance, but does not require us to abandon or neglect an intrapsychic focus.

Relational analysts, themselves not a homogeneous group, share with self psychologists a belief in the core motivating aspect of needs for connection and human responsiveness. However, they see self psychologists as neglecting the mutual impact of patient and analyst in creating current transferences and communicating insights into earlier patterns, real or fantasied, of relational experiences. Although these analysts are by no means uniform in their application of relational theory, many are critical of Kohutians for the nonparticipatory role of the analyst in the treatment situation. Bromberg (1986) states:

> Even though both schools of thought [relational and self psychology] take the dyad rather than the individual as the point of reference . . . [the former] takes as axiomatic that growth of self occurs through dyadic interchange rather than through what the patient receives in some "correct" [empathic] way. [p. 382]

Bromberg adds that, for growth to occur, the patient must see himself through the eyes of the analyst, as part of a new dialectic that includes both patient and analyst; he must become a participant-observer. In that the transference is often co-created and the analyst's inevitable countertransference must be acknowledged if not expressed, many relationists feel that using their subjectivity brings authenticity to the work. Addressing the effect the patient is having on the analyst also brings to light internalized unconscious patterns.

Self psychologists (Lachmann [2000], Schwaber [1981], and others) have answered this critique by stressing that many patients require an empathic milieu in which the analyst contains his subjectivity. In stressing that the locus of pathognomonic fixation is at a time of the formation of the self, when the self has been so traumatized as to disrupt its further development, the rationale for containment of the analyst's subjectivity until a time in treatment that a core self has been more firmly established seems cogent.

Teicholz (2000) offers a very lucid rationale for this position in citing Kohut's model and Stern's (1985) work on the stages of self development. Whereas many relationists privilege the judicial use of their subjectivity (as part of a two-person psychology), Teicholz and others point to the fact that many patients have suffered disturbances in the formation of a cohesive self at a time antedating true self and object delineation. For them, the analyst's subjective expression or disclosure of countertransferences may prematurely force on the patient the requirement to focus on the other. While it may appear to be therapeutic, because of its presupposition of a self-demarcation that does not yet truly exist, it can lead to serious ruptures or coerce a precocious acceptance of the analyst's perspective.

Once again, when the differences between the relational and self models are exaggerated, polarizations occur. However, most self psychologists seem to concur that, during the course of treatment with any particular patient, shifts in the empathic stance will occur—hopefully, as dictated by the phase-specific needs of the patient. Early in the treatment of a patient assessed to be suffering from a central self disturbance, the analyst may be required to offer an *empathic immersion,* which—optimally—focuses on the subjective needs of the patient as he strives to find attunement and confirmation for a heretofore poorly consolidated and weakly delimited self.[1] The analyst recognizes this fragility and, while not dismissive of his subjective experiences, refrains from interventions that stress these experiences, as they might unempathically shift the focus onto the analyst.

However, later on in the treatment, the impact the patient is having on the analyst may become an essential part of the treatment (Black 1987; Fosshage 2000). Thus, most self psychologists do not deny that the treatment may include a focus on the mutual impact of the two members of the dyad, but nevertheless stress the need for continual assessment of the patient's level and state of self cohesion at any given time.

[1] Bacal (1985) termed this *optimal responsiveness.*

## VARIATIONS IN SELF PSYCHOLOGICAL APPROACHES

There are also dissensions and departures from the traditional model that come from within the broad group of therapists who consider themselves self psychologists. Since Kohut's death over twenty years ago, there have been factions, often organized as various types of theoretical offspring, which have been modifying or even significantly altering the original theory. These variations of theory have some influence on the role and degree of the analyst's participation, his activity, and eventually on the nature of therapeutic action. Not unlike what takes place within other psychological models, the dialogue involves a dialectic tension between the role of interpretation, on one hand, and the place of the relationship and possible *provisions,* on the other.[2]

Stolorow, Brandchaft, and Atwood (1987) have emphasized the importance of the intersubjective experience, and stress the analyst's consistent ability to keep in mind the perspective of the psychological impact of clinical phenomena from the patient's unique point of view. Bacal (1985) has challenged the notion of optimal frustration as crucial to structural change. He has chosen the concept of *optimal responsiveness* as a linchpin of his technical recommendations. Lindon (1994), and at times Shane and Shane (1994), have pushed the theory of technique even further with an endorsement of provisions or spontaneous enactments. These latter recommendations, while always sanctioned and justified by the assertion of therapeutic yield through increasing the mobilization and the illumination of deeper transference needs (as opposed to gratifying libidinal wishes), have raised controversy and criticism from more traditional self psychologists.

[2] By *provisions,* I am not referring to individual instances of gratification, but rather to those enactments in which the analyst consciously or unconsciously attempts to meet a developmental need. A provision can be said to contribute to therapeutic action if it is followed by material that further illuminates needs and deepens the transference.

Siegel (1996) has pointed out that Bacal's (1985) critique of Kohut's reliance on optimal frustration is in error. Bacal, Siegel argues, aligns Kohut more closely to classical theory when he stresses the word *frustration,* as if Kohut felt this was the curative factor. Siegel states that it is the *optimal* aspect of the combination that should be seen as central, because it is in keeping with Kohut's overall understanding that phase-appropriate frustration includes optimally empathic responses by selfobjects, which promotes structural growth. Siegel (1996), Goldberg (2004), and others have also valued a fairly close allegiance to the primacy of insight and interpretation as most essential to achieving a therapeutic cure. Although underscoring the importance of embedding these interpretations in an empathic surround, they worry that those who favor enactments or some unusual activity on the part of the analyst are interfering with, or have a lack of confidence in, the effectiveness of interpretation and transmuting internalizations.

For those dissidents who feel (in a somewhat parallel way to certain of the relationists) that the analyst should offer more of his spontaneous and affective responses to the patient's transferences (or defenses), Teicholz (2000) provided an elegant and informed response. She reasons that, for those patients who have an arrest in self development that antedates the secure achievement of self cohesion, the analyst's appeal to reflect on the impact they have on the other (in this case, the analyst) is experienced as jarring and even retraumatizing. It requires a recognition of the other at a time in the treatment situation when this is out of tune with early developmental needs for a responsive selfobject that can withhold its own subjectivity, because to demand recognition of that subjectivity would still be premature.

However cogent and understandable are the criticisms by the more classical Kohutian analysts, I believe they may undervalue the underlying explanations of those who implicitly—or even explicitly—advocate a greater participatory role by the analyst in therapeutic action. I believe those in the dissident group are, in one way or another, grappling with two underlying themes. The first is a recognition that, for many patients who have suffered early emotion-

al deprivation and faulty response to developmental needs, the defensive structures they have constructed may not be so easily dismantled. Put differently, the pathway to achieving a "usable" new object experience—available to help rehabilitate an injured self and to facilitate progressive movement forward—may be very difficult.

Since I have chosen to employ Winnicott's (1965, 1971) "use of the object" as a crucial objective to be achieved in the therapeutic outcome of self disturbances, I will attempt to establish that there is a functional analogy between his concept and the idea of a usable selfobject. Winnicott saw the use of the object as a developmental achievement in normal maturation. When this process becomes derailed, compromise restitutive bonds and defensive solutions necessitated by the early trauma change the nature and quality of the object. For the subject, it now becomes psychologically necessary to establish an illusion of control over the object. Winnicott called this new, deformed mode of attaching *relating* to the object. Since this mode has been forged out of the need to preserve the security of the self at the expense of an ongoing capacity to establish increasing mutuality and independence, it becomes part of a pathological solution.

A crucial aim of treatment, therefore, is to facilitate a shift to permit the patient to reconnect with arrested aspects of the self through a new connection to the analyst, who can aid in the remobilizing of developmental needs so that transformation can result. According to Winnicott, part of the therapeutic yield is that, when enough growth occurs, the subject can relinquish absolute (near-"addictive") control over the object, and permit it to exist (at least in part) outside the sphere of omnipotent dominance.

I believe that an analogous experience can occur within the frame of the self model. Here, too, the end result of failed early self-selfobject connections causes such severe disjunction that a reorganization is required, one that leads to the formation of compromise bonds. The infant self requires these new pathological ties to maintain a fragile stability. However, because this attachment is imbricated with defensive features and is already a denatured

byproduct of the original need, the relationship to the selfobject is not truly "usable." In the treatment, again, the aim is to create the conditions for mobilizing earlier expressed needs onto the analyst, who can be utilized to set in motion transformational processes and can help rework unresolved negative transferences. I would then say that the analyst, through the careful process of analytic work, becomes a usable object—or, perhaps more correctly, a *usable selfobject.*

Self psychologists would maintain that the usable object of Winnicott's (1965, 1971) conception is considered an independent center of initiative, and therefore is not precisely analogous to the term *selfobject,* which has a definite emphasis on its psychological function as part of the self. While Winnicott did not have the opportunity to consider the concepts derived from self psychology, I believe—functionally and clinically—it would not violate his developmental theory to retrospectively cast his usable object as a selfobject. Again, the objective in treatment in both models is quite similar—namely, the establishment of a stable (self)object transference to the analyst, achieved in treatment through the provision of conditions that permit the gradual dismantling of maladaptive patterns of relating and crippling character pathology. Once these stable transferences are achieved, internal transformations can be accomplished through the medium of the analyst as a new and psychologically usable object.

Greenberg (1986) puts it very succinctly, stating: "If the analyst cannot be experienced as a new object, analysis never gets under way; if he cannot be experienced as an old one, it never ends" (p. 98). Much of self psychology has focused on the first part of this proposition. Hopefully, as I will emphasize in the latter part of this chapter, equal attention will be directed to the complexities involved in realizing the second half.

A second issue that self psychologists who have diverged from traditional Kohutian tenets have attempted to address concerns the role of the analyst in affect management. I think advocates of greater participation—and even of symbolic enactments—are attempting to provide a more welcoming attitude for the mobilization

of deeper transferences and frozen, often unintegrated affects. At times, the criticisms by more traditional self psychologists have been directed at the *activity* of the analyst, and have not been fully appreciative of the fact that greater participation is intended to be part of, not a substitute for, the achievement of more affective curative action.

As we have become more alert to the complexities of character development, and also of the paralyzing effects of unintegrated affects as they motivate defensive positions and influence fixed ties to compromise and archaic selfobjects, we have been forced to examine the need for a more comprehensive view of therapeutic action. If the reestablishment of a bond with a new object is a vital factor in achieving a new integration—i.e., rehabilitating pathological structures—and the freeing of affects, then one way of addressing the obstacles to this bond might be through non-interpretive modes.

I believe that a major obstacle to usability is linked to the problem of archaic, unintegrated, and often strangulated or walled-off affects. Much of character pathology and faulty selfobject relating is based on patients' defensive needs to reorganize themselves in order to avoid the awareness of dreaded affect states.

While the attempt to expand the boundaries of classical self psychology is laudable, to date there has been a minimization of the role played by affects in environmental trauma and self reorganization. Although the judicious use of provisions or enactments, the appropriate utilization of countertransference, and the attempt to apply specificity to optimal responsiveness are facilitators in treatment, remarkably few case illustrations describe the way affects emerge, impact the analyst, and eventually create enough hurly-burly to be therapeutically beneficial.

For Kohut and those who have mainly held to his original ideas about treatment, the pathway leading to therapeutic efficacy seems quite straightforward. The bit-by-bit interpretive work, as selfobject transferences become established and gradually become internalized as part of new structures, seems quite simple. Inevitable breaks or failures in empathy and the vicissitudes of individual nar-

cissistic configurations can lead to disruptions and shifts in the patient's behaviors, such as temporary regressions, renewed symptomatology, and altered self states, all of which require close attention and attunement on the part of the analyst. But the process of working through is mostly assigned to transmuting internalization, and the end result of disruption and repair is the gradual replacement of the function of the analyst by the patient's own, now more enlivened and strengthened self.

While Kohut has certainly directed our attention to the effect of early environmental trauma on the developing self, he wrote quite sparingly about the total impact on the individual child. The effects of repeated misattunement and phase-inappropriate responses on narcissistic strivings—including the production of rigid mirroring and idealizing needs, other pathological reorganizations, compromised selfobject ties, archaic states of grandiosity, and a chronic hunger for a new selfobject—have been well described. But early failures involve more than deprivation in the dimension of mirroring and idealizing needs. Of equal importance has been their effect on the fate of the affects, and specifically on feelings of despair, hopelessness, and loneliness, and the reactive rage inextricably linked to the inadequate selfobject response.

## ENHANCING KOHUT'S FORMULATIONS

In his efforts to remain associated with traditional analytic theory, and consistent with his own classical training, Kohut expressed his formulations in a somewhat stilted language that often appeared to be devoid of experience-near terms such as attachment, dependency, loneliness, and rage. While he advocated the use of empathy, tact, and acceptance, the weight of his formulations seems to have been determined by the psychoeconomic point of view. For example, let us look at Miss F, whom he describes in detail in his book *The Analysis of the Self* (Kohut 1971), and who compelled him to revise his clinical thinking.

In the case material, Kohut relates how Miss F would come home from school and begin to tell her mother some "exciting"

incident, hoping to find a responsive gleam in the latter's eye. However, rather quickly, she would find her mother's attention waning or subtly shifting the focus onto herself. These scenes, repeated in other analogous settings, were understood by Kohut as determining the fate of Miss F's phase-appropriate grandiose and mirroring needs. In effect, as her maternal selfobject failed her, the claims for attention and attunement went underground, remaining in repression in an unmodified form. Yet it was those needs that were mobilized in the analysis and, until grasped by Dr. K, they were the cause of profound rage, despair, and retreat into archaic states.

Kohut came to understand the source of Miss F's chronic anxiety and her fear of entering into more intimate relations as stemming from the danger that she would not be able to tolerate the breakthrough of unmodified claims of her grandiose self. To avoid the dedifferentiated intrusion of these narcissistic strivings, which threatened a weakened self structure, she walled off her more deeply buried emotional needs. The evidence that these needs were still alive was indicated in the treatment through outbursts of rage, activated at those times when Kohut misunderstood the significance of her unique narcissistic transference.

Kohut's emphasis on the psychoeconomic imbalance, i.e., a weakened self endangered by the pressure of overstimulation and unmodified hypercathected strivings, led him to utilize a language that seemed to deemphasize what Miss F's lived-in experience, her inner world, might feel like. While, psychoeconomically, she might dread overstimulation and be incapable of protecting a fragile self, the affective consequences of early environmental trauma might be more evocatively described as her feeling unresponded to, unlovable, and alone. From a conflict perspective, her fear of exposing her profound needs for mirroring and affective attunement was due to the perceived risk of encountering a lack of responsiveness that, in turn, would evoke the unbearably painful affects that remained unintegrated, yet accompanied the memory of her unmet needs.

I believe it is necessary to consider incorporating a language in our case descriptions that addresses a range of emotional states re-

sulting from early selfobject failure, because this can offer us an expanded way of looking at the complexity of character formation. If we have only a psychoeconomic explanation for the patient's anxieties, and with which to explain the motive for protective defenses, we may too often minimize the role of unintegrated affect states, insofar as they help determine the fate and quality of developing self-selfobject relations, and, in the treatment situation, as they influence the capacity to utilize the analytic relationship to effect optimal change.

Tolpin (1971) lucidly outlined the process of transmuting internalization by referring to a baby, assisted by an empathic mother, who can slowly begin to self-soothe and self-regulate. Thus, in the face of acceptable frustrations and a moderate increase in tension states, the baby begins to take over the mother's functions and calm itself. But our patients are people who were children—traumatized ones, at that—and who are burdened with the memory of extremely painful and toxic experiences derived from early selfobject failures.

Several self theorists linked closely to Kohut's views have indeed addressed the role of affects. Basch (1976) wrote about the faulty integration of feelings and its consequences for maturation and character. Wolf (1988), in discussing therapeutic action, stated that a patient's self is strengthened by reexperiencing the archaic trauma, *with its associative affect,* in the here and now of the therapeutic situation. He does not see the beneficial yield as part of an engineered, "corrective" emotional experience, but as evolving from inevitable and at times painful disappointment and a resultant disruption in the tie to the analyst. The analyst's empathic understanding and eventual aid in explaining the break can contribute to the patient's new ability to integrate heretofore disorganizing experience.

What I believe Wolf is describing here is that the analyst, through the sequence of disruption and repair, provides a new experience with a selfobject that, through its capacity to *hold* negative affects (analogous to Winnicott's views on holding and surviving destruction), permits a new integration to take place. While

many self theorists (Wolf, Siegel, and others) have highlighted the repair/disruption sequence as vital to the ongoing therapeutic process, the emphasis on the analyst as the provider of a specific container function is more often an implicit one. If the analyst can successfully help the patient manage the turbulence of intense and often hostile feelings, this may serve as a paradigm for a new relationship to the self, and, internally, to the patient's selfobject, in regard to affects. A dilemma in the technical handling of these ruptures is that, paradoxically, the analyst's empathic grasp of the causative factors in the current self-selfobject breakdown might prematurely close off the full range of the injury, or not allow sufficient time or intensity for the experience of its emotional sequelae to be developed.

Stolorow, Brandchaft, and Atwood (1987) raised the issue of selfobject failure in the dimension of affect integration as it influenced the repetitive transference. They noted that the unreliability or unavailability of early caretakers in response to narcissistic injuries led to increments of affect intensity that, if not adequately managed, ultimately caused a noxious watershed in psychic development. Specifically, the injured self, disappointed and rageful, if not helped with containment, would ultimately need to reorganize itself. Such a shift can bring about serious characterological changes, resulting in severe, crippling defenses and significant compromises in the relationship to the self and others (e.g., pathological ties of accommodation).

With this focus, more emphasis is placed on character presentation as a defense against retraumatization, particularly related to the fear of activating disorganizing affect states. In fact, from this perspective, I believe it is possible to view fragmentation anxiety in the following way: the patient fears losing connections to needed selfobjects (both defensive archaic bonds and more wholesome attachments) because this not only entails the loss of essential ties, but also because the affects linked to the disruption are experienced as overwhelming and unmanageable, and hence threatening to the integrity of the self.

Fosshage (2000), in a discussion of a paper about the fate of narcissistic rage, states that Kohut's emphasis on the selfobject

transferences inadvertently minimized the importance of the repetitive aspects of the transference. Again, we find a reference to narcissistic character pathology as derived from defensive adaptation. In a similar vein, Stolorow, Brandchaft, and Atwood (1987) see the pathological relational patterns that are often inextricably interwoven with more deeply embedded needs as attachment bonds that are devitalizing, conflictual, and self constricting. Their view is that a major factor in the formation of these defensive configurations is the faulty management of affects, which I would identify as a second dimension of selfobject failure.

As our broadening understanding of the complexity of narcissistic disorders grows, it seems inevitable that there will be a proliferation of splinter groups that are explicitly or implicitly struggling with limitations in the original theory of treatment. Further, as current writers (e.g., Fosshage 2000; Newman 1999; Stolorow, Brandchaft, and Atwood 1987; Wolf 1988) have noted, the role of affects must be repositioned as more central to the motivation for the creation of compromise bonds, and as responsible for potentially understandable but profound character resistances to change.

If we view our analytic goal as providing conditions suitable for achieving usability, we must account in the treatment situation for those defensive structures that pose significant obstacles to reaching this aim. I believe patients are motivated to maintain pathological ties to themselves or others by their deeply experienced fear of reactivating the affect states linked to the originally needed selfobjects. If this dread is in turn connected to a partially neglected dimension of selfobject failure, then we should amplify our theory of therapeutic action to include ways to engage and eventually rework toxic affects.

## THE CENTRALITY OF AFFECTS

I will begin this section with a schematic view of the patient's inner world as it exists subsequent to repeated narcissistic injury, with particular focus on the fate of affects and the way internalized selfobjects as "structures" are imagined. Here my intent is to em-

phasize a representational world in selfobject terms that take into account two dimensions of selfobject failure. Having imagined the state of self and selfobjects following profound injury and, in turn, how this affects character pathology and adaptation, I want to propose the following: if character involves two sectors of need—the one communicating the continuing presence of yearnings for the mirroring or idealizing selfobject, and the other the need for the selfobject associated with containing and regulating affect—then either of these sectors may appear as the leading edge of need.

To more fully imagine how these two dimensions of failure and need become imbricated within the presenting character requires further exposition of the effect of the failures of early self-selfobject experience, thereby giving the second dimension its deserved importance in shaping character and ultimately influencing therapeutic action. I will underscore the role of affects. I want to give particular emphasis to the way selfobjects were internalized in relationship to negative affect states, in order to delineate an explicit concept of negative selfobjects.

While Kohut always recognized the crucial importance of early selfobjects for their soothing and self-regulating functions, the centrality of affects—or the need to contain unmanageable feeling states motivating defensive restitutive character formation —seems to have been minimized. Failures in selfobject responsiveness to infant needs always have two major consequences. The one concerning interference with narcissistic strivings, thwarting forward developmental progress and causing intensification and fixation of needs, has been well documented. At the pole of the grandiose self and its selfobject complement (mirroring, twin, alter-ego), prolonged disturbances lead to deformation and intensification of needs (e.g., perversions, addictive behavior, etc.) and/or severe compromises in relations to others (pathological ties) or to the self (archaic expressions of grandiosity).

But the second and equally important result of the thwarting of narcissistic needs is the activation of painful and often negative emotional intensities. Winnicott (1965, 1971), with the notion of holding, and Bion (1962), with the concept of a container func-

tion, addressed the activities required of what we would now refer to as the good enough selfobject, managing rising tension states and communicating paradigms of calming. This capacity becomes seriously challenged when the early self-selfobject bond is threatened by inevitable occurrences of empathic breaks, misattunements, and other psychological frustrations. If these rising affect states are avoided, excessively criticized, or in some way mismanaged, the result can be that the child's self is flooded by an overwhelming, unintegrated tide of feelings. On one hand, this can be a nidus for the disruption implied by the concept of fragmentation anxiety, and it can also become the watershed (Stolorow, Brandchaft, and Atwood 1987) for a need for major reorganization, often leading to significant pathology.

We can imagine the representation of self and selfobject as having now been altered secondary to this double environmental failure. Stern's (1985) evocation of the inner world of the infant offers a reference point for the idea of negative internalized selfobjects. His concept of RIGS—Representations Internalized Generalized—could well apply to the legacy of the child's experience with his needed caretakers. Selfobject functioning can be positive, enhancing self-cohesion and facilitating forward development. This functioning also provides ideals that serve as models for self regulation or as figures of admiration. But, conversely, the child and incipient patient may have an in-dwelling sense associated with the thwarting of these needs and the mismanagement of the states of affect intensity that follow.

Thus, in the dimension of narcissistic need (mirroring, validating, enhancing, etc.), critical, insufficient, or faulty responsiveness leaves the child with a negative legacy, a hungering for objects to fulfill his needs. In comparison to the child who has healthy encounters with selfobjects, the one who experiences misattunements or toxic responses will be left injured, with a concretized internal picture and a negative selfobject. Thus, the experience of the critical disruptive need—as occurs again in analysis—is accompanied by fear of reactivating this negative selfobject.

In the second area of selfobject need, i.e., the dimension related to holding, containing, and regulating of tension states, if the

parent is unavailable, too critical, or too injured by the child's intense hostility or depressive affects, these also will be "laid down" as negative selfobject experiences. Consequently, not only may the patient fear the reactivation of early need states, but he may also fear his reactive affects. Having been thwarted or rebuffed repeatedly, the patient anticipates the danger of being flooded with his emotions in all new relationships, which is further complicated by his preconscious awareness of the lack of an internal structure to successfully integrate or manage these emotions. It is around this twofold failure that the child's needs to reorganize in order to maintain the self find some way of making connections with substitute versions of needed selfobjects, while at the same time staving off an awareness of painful and feared affect states.

Pathologically adaptive character relationships, the deformation of archaic grandiosity, and emergency symptomatology (often imbricated with drive expressions) all serve to communicate tendrils of need states carried forward into the personality, as well as the need for protection and defense against the hoped-for but dangerous reawakening of need states. What interferes with the activation of deeper transference states is not only the patient's memory of being misunderstood or criticized for the needs embedded within, but also the intuitive knowledge that archaic affects linked to frustration cannot be negotiated. So, while the prescription for treatment is clearly designed to provide a clinical situation that accepts the patient's needs and facilitates their mobilization, the patient's fear of encountering the toxic objects (which I refer to as negative selfobjects) mobilizes severe conflicts.

While the aim is to achieve a *usability* (Winnicott 1965, 1971) that provides an opportunity to rehabilitate derailed structures and liberate frozen affects, the nature of the obstacles to be overcome, in the form of the inner world of danger that threatens the patient if new experiences are offered, can prove extremely challenging. I am suggesting, then, that the dimension of a failed holding environment plays a crucial role in preserving old rigid structures and pathological ties and in preventing genuine usability. The corollary is that, at base, the patient's fear of the destructive power

of his feelings—destructive to the self and to the other—lies at the root of resisting usability. Many analysts have recognized that, for analytic work to achieve depth if not completeness, archaic affect states must be engaged and lived through the analysis.

Winnicott's term *survival of destruction* is a metaphor describing the child's gaining of confidence that his caretakers will not withdraw, be overly critical, or somehow emotionally abandon him in the face of protest, disillusionment, and rage. As the self is strengthened in this sector, the object can be placed outside the sphere of absolute control and is now "usable." A parallel metaphor can be expressed in self psychological terms. Often, it is the absolute dread of reexperiencing the painful feelings of aloneness, the recognition of the failure of the selfobject—and, above all, the frightening rage that accompanies such awareness—that keeps in place pathological ways of relating to the self or to others.

Let me now provide a brief description of a clinical case viewed from within this framework in order to illustrate how these principles can be usefully applied to enrich and deepen the analysis.

## CASE ILLUSTRATION

R came to analysis to learn more about herself. She did not complain of any particular problems, other than that she felt she was a "driven" person and rarely could allow herself free time. She was happy in her present, second marriage, had children from a previous marriage, and was now embarked on a second career.

In the early sessions, R talked about her efforts to fill her time with meaningful work or other activities. She had always succeeded, although she acknowledged that she was somewhat of a perfectionist and could become intimidated when she had to present herself to authorities. Only as she filled in her history did she begin to recognize that she could be quite anxious lest she be judged. To keep this from happening, she was always prepared and tried to gain approval. She also noted that she was especially sensitive with women, from whom she would fear any negative sign. Having

a good aptitude for the process, she quickly associated the apprehension regarding female mentors with her mother. But, for the most part, she felt she and her mother got along and were close. Her father, on the other hand, could be somewhat judgmental.

Most of the above emerged from the couch, as R quickly adapted to analytic work. The excerpts I want to highlight came from an hour about three weeks into the analysis. The patient was reporting a dream and, after several minutes, became quiet and then a bit flustered. "I lost my place," she said. "I was telling you something and then I forgot where I was going." I remained silent, and she said, "Oh, dear—I'm beginning to feel anxious about not being somewhere I was going with this . . ." At this moment, I made a decision to remain silent, even though R was in some mild distress.

Now let me say that, until this moment, the work had proceeded quite smoothly—almost, we might say, without a pause. R took to the process, attempting to be helpful, clarifying, and even making useful connections. Anxiety was not a significant factor, although it had been mentioned in association with performance.

When I decided to allow the anxiety to mount, I must admit I was departing from the way I might have handled similar situations early in an analysis. I might have more or less automatically provided a bridge or a linking sentence to help her reconnect her thoughts. I would have considered that this amounted to alliance building and offering a tension-regulating function. But this time, I thought it might be useful to help her become aware of her anxiety in the context of not being able to confirm that she was a "good" patient. And, in fact, that was what she said: "I'm afraid I'm not doing it right and I'm feeling uneasy."

Then I inquired, "So when you don't feel you are getting an 'A' in association, what happens to you?" Rather than becoming more anxious or disorganized, R allowed herself to experience just what and who she was "bumping into" within her internal world. What emerged was a flood of associations delineating all the times she would overprepare for exams, orals, and interviews. The dread was that the authority figure would be critical or look

away. She had nearly always been successful at keeping away from the intolerable possibility that she wouldn't gain a smile or the gleam in the other's eye.

Did I say *other*? Well, rapidly, the patient said *mother*. The analysis now took on a distinctive direction in which, for the first time, R became aware of a problematic relationship with her mother. She began to recognize how hard she had to work in order to maintain her mother's interest. In fact, she was so successful most of the time that the disquieting awareness of a flaw in the relationship was covered over. Embedded in the recognition of a disturbance in the bond was the pervasive dread of affects. As we learned, to be aware of not being approved of was bad enough, but beneath that was her terror of her own negative feelings.

For R, painful and negative feelings had needed to be kept out of awareness since early in her history. Paradigmatically, she had had severe abdominal distress, which caused her great pain; her mother couldn't bear the screams and would only come into her little girl's room if she were quiet. Any display of depression or emotional dysphoria was too much for her to bear and she would discourage its expression.

In the following months of analysis, R gradually came to see how delicate a balance existed in her relationship with her mother. Because of the patient's ability to enliven her mother, especially utilizing her talents and intelligence, it was rare for the patient's feelings of loneliness or disappointment to enter her consciousness. But one startling incident occurred that mobilized intense feelings. R had always believed that she was indispensable to her mother, and that her mother would drop everything to be with her. Yet, on an out-of-town visit, the mother's already arranged plans took precedence over time for her daughter. This exploded the myth of specialness and opened up a wellspring of pain and, for the first time, intense anger.

I emphasize the flow of the analysis in the first year or so because it was largely focused on the emergence of negative affects. While it was clear that performance, accommodation, and driven efforts were the way the patient had reorganized in order to main-

tain a tie to her primary object (selfobject), the thrust of the analysis was on the efforts to avoid the recognition of loss and pain.

Toward the end of the second year of our work, an incident occurred that brought into the treatment affective intensities that directly related to the transference. Until this time, it had seemed to me that, while our alliance was positive, we had reached a plateau. While R felt a great sense of attachment and apparent trust, I felt she was always "playing" to me, and that analysis was "work," just as being with her mother was an emotional strain. While we could identify this aspect of transference and its standing in the way of allowing deeper intimacies, it remained fixed in place.

It was only when an empathic rupture occurred in the analysis that a breakthrough took place. I had failed to fully appreciate the meaning of a milestone occasion and, although she initially was reluctant to acknowledge her feelings, they burst onto the scene. For the first time, R became openly angry, hurt, and sad, and felt distant from me. She then attempted to retreat from her feelings, ashamed that she should expect "so much" and should be so angry. But now we could connect the immediacy of these affects to the work we had done in the early stages. We could link the patient's fear of her strong and stormy emotions to her fear that I would be overwhelmed and she would be abandoned. Based on her early experiences, R saw herself as toxic and destructive if she were to upset her main love objects. If her pain and rage emerged, her mother would disappear, and she was afraid she did not have the internal resources to contain them.

What I want to stress about the way this analysis unfolded is that, until R and I both felt the full impact of her affective life in living color, her more deeply buried needs for positive mirroring and affirmation were held in abeyance. While it appeared that our relationship was positive, it was not deepening. I was essentially still being related to (albeit less ambivalently) as part of a compromise bond. It took a living out of the powerful negative affects, and a demonstration that they could be survived, for us to be able to reach a deeper level.

I am not claiming that a sequence attending to warded-off negative affects is always necessary as a precondition to the mobilization of positive feelings. But for many patients who have never felt confident in their capacity or that of their objects to bear affects, pathological situations and compromise relations are resistant to change because of the profound anxiety that their psyche cannot withstand the tension associated with disillusionment. Such patients may need an intensity, a lived-through experience in the transference, to know that the analyst can manage and survive these tension states. In these cases, the forward edge, the central and often initial dimension of selfobject need that must be attended to, is to be found in the realm of the holding environment.

## SUMMARY

All the divergent factions in self psychology preserve Kohut's basic concepts, and I believe that the attempt to widen the scope of analytic engagement is also common to all of them. While often not explicitly stated, the intent is to provide an intense facilitating atmosphere that is still secure enough to effect a reworking of archaic affects. To help the patient move from archaic self organization to more stable, solid, and usable narcissistic transferences requires the analyst to strive for a broader application of empathy, a more encompassing way of working with our subjectivity, and expanded concepts of countertransference specific to self psychology. Since early environmental failures have often resulted in negative templates (Gehrie 1996), fixed ties of pathological accommodation (Brandchaft 1993), and other complex character formations, it is not surprising that the aims of treatment cannot be easily achieved. Each of the new schools under the self-model umbrella is attempting to find ways to provide the optimal conditions through effective participation, and to engender in patients the hope and confidence that a new developmental experience is possible.

Self psychologists have long recognized that, imbricated within their patients' presenting character, their complex symptomatol-

ogy, and their faulty relationships are derivatives and tendrils representing the preserved need for selfobjects. When the analyst accepts and illuminates these needs, he is tacitly endorsing this forward edge and will further endeavor to mobilize the deeper configurations that contain these needs in order to deepen the analysis.

Kohut's original conceptions of treatment seemed to downplay the defensive role of character. The spirit of his new formulations shifted focus away from resistance analysis. In contrast to the existing traditional view of character defenses as primarily organized to constrict the expression of conflictual impulses and avoid superego criticism, Kohut defined defenses as protective organizations designed to prevent retraumatization. He constantly worried that too great an emphasis on the resistance aspects would confine treatment to an analysis of drives.

However, the recognition that complex defensive organizations are designed not only to protect against retraumatization, but also to contain unintegrated affect, illuminates the role that selfobjects play in providing a holding function. In view of the fact that many of our patients present with pathology that reflects a failure in the selfobject-as-container-function, it follows that this dimension of need should emerge as a forward-edge transference in its own right. Further, as a part of the analytic process—and crucial to the aim of therapeutic outcome attending to this deficit—the patient's achievement of the capacity for affect regulation might entail the analyst's provision of a different function than if the focus were on mirroring needs.

## REFERENCES

Aron, L. (1996). *A Meeting of Minds.* Hillsdale, NJ: Analytic Press.

Bacal, H. (1985). Optimal responsiveness and the therapeutic process. *Progress in Self Psychol.,* 1:202-227.

Balint, M. (1968). *The Basic Fault: Therapeutic Aspects of Regression.* New York: Brunner/Mazel.

Basch, M. F. (1976). The concept of affect: a reexamination. *J. Amer. Psychoanal. Assn.,* 24:759-777.

Bion, W. R. (1962). A psycho-analytic study of thinking. *Int. J. Psychoanal.,* 43:306-310.

BLACK, M. (1987). The analyst's stance: transferential implications of technical orientation. *Annual of Psychoanal.,* 15:127-142.

BRANDCHAFT, B. (1993). To free the spirit from its cell. *Progress in Self Psychol.,* 9:209-230.

BROMBERG, P. (1986). Discussion [of Goldberg]. *Contemp. Psychoanal.,* 22:374-386.

FOSSHAGE, J. L. (2000). The meanings of touch in psychoanalysis. *Psychoanal. Inquiry,* 20:21-43.

GEHRIE, M. (1996). Empathy in broader perspective: a technical approach to the consequences of the negative selfobject in character formation. *Progress in Self Psychol.,* 12:159-179.

GOLDBERG, A. (2004). *Misunderstanding Freud.* New York: Other Press.

GREENBERG, J. (1986). Theoretical models and the analyst's neutrality. *Contemp. Psychoanal.,* 22:87-106.

KERNBERG, O. F. (1974). Contrasting viewpoints regarding the nature and psychoanalytic treatment of narcissistic personalities: a preliminary communication. *J. Amer. Psychoanal. Assn.,* 22:255-267.

KOHUT, H. (1971). *The Analysis of the Self.* New York: Int. Univ. Press.

LACHMANN, F. (2000). *Transforming Aggression: Psychotherapy with the Difficult-to-Treat Patient.* Northvale, NJ: Aronson.

LINDON, J. A. (1994). Gratification and provision in psychoanalysis—should we get rid of "the rule of abstinence"? *Psychoanal. Dialogues,* 4:549-582.

NEWMAN, K. (1999). The usable analyst: the role of the affective engagement of the analyst in reaching usability. *Annual of Psychoanal.,* 26:175-194.

SCHAFER, R. (1983). *The Analytic Attitude.* New York: Basic Books.

SCHWABER, E. (1981). Empathy: a mode of analytic listening. *Psychoanal. Inquiry,* 1:357-392.

SHANE, M. & SHANE, E. (1994). Self psychology in search of the optimal: a consideration of optimal responsiveness; optimal provision; optimal gratification; and optimal restraint in the clinical situation. Paper presented at the Annual Conference on the Psychology of the Self, Chicago, IL.

SIEGEL, A. (1996). *Heinz Kohut and the Psychology of the Self.* New York: Routledge.

STERN, D. N. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology.* New York: Basic Books.

STOLOROW, D., BRANDCHAFT, B. & ATWOOD, G. (1987). *Psychoanalytic Treatment: An Intersubjective Approach.* Hillsdale, NJ: Analytic Press.

TEICHOLZ, J. G. (2000). *Kohut, Loewald, and the Postmoderns: A Comparative Study of Self and Relationship.* Hillsdale, NJ: Analytic Press.

TOLPIN, M. (1971). On the beginnings of a cohesive self—an application of the concept of transmuting internalization to the study of the transitional object and signal anxiety. *Psychoanal. Study Child,* 26:316-352.

WINNICOTT, D. W. (1965). *Maturational Processes and the Facilitating Environment*. New York: Int. Univ. Press.
——— (1971). *Playing and Reality*. London: Tavistock.
WOLF, E. S. (1988). *Treating the Self: Elements of Clinical Self Psychology*. New York: Guilford.

---

*122 South Michigan Avenue*
*Room 1315B*
*Chicago, IL 60603*

*Psychoanalytic Quarterly, LXXVI, 2007*

# INTERSUBJECTIVITY, THERAPEUTIC ACTION, AND ANALYTIC TECHNIQUE

BY OWEN RENIK

*The author defines the therapeutic action of psychoanalysis as the patient's increased capacity to make changes in his/her attitudes or behaviors in order to achieve greater well-being and satisfaction in life. Although most analytic theories generally agree about this, the author notes, they diverge in their specifications of the principles of analytic technique that will best accomplish this aim. The patient's experience of benefit is the most accurate criterion for evaluating the success of the analysis and thus of the resultant therapeutic action, in the author's belief. An extended clinical vignette is presented in which he illustrates how his technical decisions are guided by these principles.*

I find that patients usually seek psychoanalytic treatment with what is at heart a simple agenda: they want to feel more satisfaction and less distress in their lives. If I am able to help someone, it is because the way he/she constructs his/her experience is less than optimal for the purposes of pursuing satisfaction and avoiding distress, and the construct can be altered: certain of the patient's expectations, assumptions, and decision-making can be reviewed and revised, as a result of which the patient's attitudes and behaviors change so as to afford the patient a feeling of greater well-being.

---

Owen Renik is a Training and Supervising Analyst at San Francisco Center for Psychoanalysis, an Associate Editor of *The Psychoanalytic Quarterly,* and former Editor of *The Psychoanalytic Quarterly.*

Such, in my view, is the therapeutic action of clinical psychoanalysis; and it seems to me that any number of psychoanalytic theories describe it, though each uses a particular vocabulary with a particular emphasis. Conflict theorists speak of alterations in the patient's compromise formations, i.e., in the way the patient manages his/her complex motivations; self psychologists speak of reparative selfobject transferences that allow the patient to regain adaptive narcissism; control mastery analysts speak of the analyst disconfirming the patient's pathogenic beliefs (a version of corrective emotional experience); developmentalists speak of the patient reworking stages of separation-individuation; and so on. These are all descriptions of the same process—a review and revision of the patient's expectations, assumptions, and decision-making, the way the patient constructs his/her reality—seen from different angles of view. To think otherwise is to make the mistake of the blind men with the elephant.

This is not to deny that divergent views regarding therapeutic action exist among various psychoanalytic theories. Far from it. However, if we rise above the narcissism of small differences, I think what we see is that the significant distinctions do not really concern the *essential nature* of therapeutic action as much as they concern the question of *how to bring about therapeutic action*. In other words, it is my impression that the important controversies with regard to the therapeutic action of clinical analysis really concern differences in *principles of technique*—which should follow closely from fundamentally different conceptions of therapeutic action, but which, in fact, often do not.

For example, a great many colleagues are willing to agree that a successful clinical analysis depends, somehow or other, upon a series of corrective emotional experiences. But very few endorse the presumption and contrivance of the clinical method recommended by Alexander and French (1946) for providing corrective emotional experiences. Similarly, while contemporary analysts may differ to some degree as to the role of conscious insight, most allow that nonverbal factors are crucial; and on that basis, there is widespread acceptance of the idea that for clinical analysis to suc-

ceed, the patient has to live through a series of transferences whose effect is, ultimately, reparative. At the same time, there is considerable criticism in many quarters of how self psychologists approach their patients.

Recently, a great deal of attention has been paid to the recognition that when a patient's construction of his/her experience can be successfully reviewed and revised in clinical analysis, this review and revision are accomplished via an intersubjective exchange between analyst and patient. This "intersubjectivist" or "relational" orientation—at least as I understand it—does not in itself indicate an altered conception of the therapeutic action of clinical psychoanalysis. What an intersubjective perspective offers is increased appreciation of the epistemology of the clinical analytic encounter. And that has decisive implications with regard to how an analyst optimally goes about arranging for the therapeutic action of clinical analysis to take place—i.e., for our theory of technique.

To begin with, a reconsideration of analytic expertise and authority is called for. Rather than an expert on understanding the patient's psychic life, the analyst is an expert on facilitating a collaboration that permits the patient to understand his/her own psychic life. Instead of an authority who reveals hidden truths to the patient, the analyst is a partner who works with the patient to create understanding concerning the way the patient constructs his/her reality, and to revise the patient's constructions of reality so as to afford the patient less distress and more satisfaction in life. In a successful clinical analysis, co-created old truths are replaced with co-created new truths. To differentiate between creation and discovery in clinical analysis is to establish a specious dichotomy.

The vehicle for collaboration, of course, is the dialogue—spoken and unspoken, conscious and unconscious—that takes place between analyst and patient. The ground rules that are established for the clinical analytic dialogue will structure the intersubjective encounter that ensues and what it produces. Traditional principles of clinical analytic technique have established ground rules that privilege the analyst's voice in the dialogue. Perhaps most important, this has happened because our theories of psychoanalytic

process—and, therefore, our principles of technique—have directed analysts to apply their clinical efforts toward the achievement of special, specifically psychoanalytic goals, formulated separately from therapeutic goals. In fact, analysts are warned against therapeutic zeal, which is understood to interfere with the pursuit of psychoanalytic goals. Specifically psychoanalytic goals necessarily derive from psychoanalytic theories. Therefore, when clinical work aims at accomplishing specifically analytic goals, the analyst, who is an authority on analytic theory, is established as an authority on clinical progress and outcome.

A problem with privileging the analyst's voice in the dialogue and making the analyst an authority on progress and outcome is that it disposes to circularity in clinical investigation. The analyst's subjectivity dominates the intersubjective exchange and the co-creations produced by it. What comes to be understood reflects what the analyst assumed in advance. Obvious evidence of this is the fact that successful clinical analytic results around the world tend to differ predictably, according to the psychoanalytic subculture to which the analyst belongs: in one locale, a clinical analysis is understood to conclude successfully when the patient's primal scene fantasies are exposed; in another, when the patient moves beyond the paranoid-schizoid position; in still another, when the patient successfully achieves rapprochement; and so on.

Acknowledging the intersubjectivity of clinical analytic work exposes the problem of circularity and indicates the need to establish outcome criteria for clinical analysis that are independent of psychoanalytic theory. In my opinion, analytic purposes are best served by using the patient's experience of therapeutic benefit as the outcome criterion by which the success of clinical analytic work is judged. Obviously, a patient's self-evaluations and self-reports concerning therapeutic benefit will always be highly overdetermined. Nonetheless—whatever the inevitable role of compliance, opposition, etc.—a patient's judgments of therapeutic benefit are based on observations made external to the treatment relationship and the clinical setting. This gives the possibility of constructing clinical analysis as an experimental situation, however

imperfect. Psychoanalytic propositions can be tested by measuring a dependent variable: valid insights are ones that produce enduring therapeutic benefit; useful analytic techniques are ones that produce valid insights.

This approach to validation in psychoanalysis, which follows from acknowledging the intersubjective nature of clinical analytic investigation, is often misconstrued to have a hermeneutic orientation because it legitimizes narratives, co-created by analyst and patient, as psychoanalytic propositions. On the contrary, this approach is scientific. Science always deals in narratives, whether those narratives are competing versions of quantum mechanics in physics or various psychodynamic formulations in a clinical psychoanalysis. What science requires is that the claims of differing narratives be adjudicated on a pragmatic, empirical basis—i.e., that an experimental situation be established in which narratives can be evaluated according to their ability to predict.

In hermeneutic disciplines, like literary criticism or political history, data do not permit use of prediction as a basis for validation of propositions. Other criteria must be used—aesthetic criteria such as elegance, coherence, or rhetorical appeal. When specifically psychoanalytic goals are pursued in clinical analysis, circularity gets built in and aesthetic criteria are used to assess insights—i.e., explanations that analyst and patient find persuasive are held to be valid; validation of insights is not accomplished by testing predictions concerning an independent variable. Therefore, when specifically analytic goals are pursued, clinical analysis becomes a hermeneutic, rather than a scientific, enterprise.

For me, then, a patient's experience of increased satisfaction and decreased distress in life is the only outcome criterion by which the success of analytic work can be judged. Analyst and patient together may arrive at an understanding of the patient's psychology that offers a comprehensive and elegant explanation of the patient's difficulties, that takes account of the patient's history, the patient's experiences and behaviors both within and without the sessions, an explanation about which both patient and analyst are quite convinced; but if that understanding is not accompanied

by a subjective judgment of increased satisfaction and decreased distress on the patient's part, the validity of the understanding—its completeness, at least, if not its accuracy—must be doubted.

These methodological considerations have very practical consequences. An analyst's theoretical assumptions are a crucial part of the analyst's subjectivity, and often have a decisive influence upon clinical work. I offer the following case example to illustrate how my moment-to-moment technical decisions are determined by using the patient's experience of therapeutic benefit as the outcome criterion by which the validity of the understanding gained in clinical analysis is judged. (My reflections upon the material are presented in brackets.)

## CLINICAL VIGNETTE

Ellen, a schoolteacher in her late forties, sought treatment for her depression. It soon became obvious that Ellen was depressed in no small part because she badly wanted to have a satisfying relationship with a man, but had become convinced that she was unable to establish one. For the past fifteen years, she had essentially stopped even trying. Now, as her fiftieth birthday approached, she felt awful about what seemed destined to be the permanent emptiness of her romantic life. She undertook an analysis as a last resort, to see if there might be any way to change her bleak prospects.

When she was young, Ellen had not been comfortable with boy–girl socializing. She always felt unattractive and inept. She did not date at all in high school. In her last year of college, at age twenty-one, she became extremely attracted to Richard, a sixteen-year-old high school student in one of the classes that she student-taught. The fact that she was older permitted her to feel confident enough to begin a relationship with him. They started to go out, against the strenuous objections of both their families. When Richard graduated, they got married and moved to San Francisco, where he enrolled in college and she got a teaching job.

Ellen found Richard beautiful. She felt that she was completely in love with him and he with her. However, she realized that Rich-

ard had some growing up to do. Their marriage was never consummated. Nonetheless, Ellen cherished fantasies of their future together: Richard would become a successful businessman; they would have children and live in a big house in a nice neighborhood. In fact, Richard did not do very well in his courses. He was undisciplined, got into drugs, and eventually dropped out of college. When, after five years, he asked for a divorce, Ellen reluctantly agreed.

Ellen was ashamed of how unrealistic she had been about Richard. It made her feel even more insecure about herself as a woman. After her divorce, she dated only rarely. She was thrilled when she met Paul, who became completely smitten with her and pursued her vigorously. Paul was an ardent and experienced lover. With him, Ellen had her first fulfilling sexual experience. Eventually, they moved in together.

Gradually, Paul's sadistic interests, which had always been present, became more and more pronounced. Ellen did not enjoy the bondage and other dominance-submission games that Paul insisted on, but she went along. She assumed Paul was right when he accused her of being sexually inhibited. When Paul began staying out late, Ellen ignored her suspicions that he was unfaithful. One night, he brought home a lover and suggested a threesome. Ellen refused. She was terribly hurt. In the morning, Paul moved out, and Ellen was devastated. After that, she never developed another relationship with a man.

Ellen enjoyed friendships with women, which tended to be carefully selected and intimate. At one point, pessimistic about ever finding happiness with a man, she tried to start a lesbian relationship with a woman about whom she cared deeply; but it just didn't work. Ellen liked sex with a man, and she couldn't get that out of her mind. The lesbian relationship went back to being just a friendship. From then on, after a few desolate one-night stands with men, Ellen's sex life came to consist exclusively of masturbation, her fantasies usually involving unavailable men of her acquaintance—married co-workers or friends' husbands—on whom she developed hopeless, secret crushes.

Ellen saw her terrible image of herself as having been caused by her mother's relentless criticism of her throughout her childhood. As far back as Ellen could remember, her mother had held up an image of what Ellen was supposed to be like, and had made it clear to Ellen that she was constantly falling short. When Ellen's mother was on her deathbed and Ellen came to the hospital to say goodbye, her mother turned her face away in disgust, refusing to talk to Ellen or even look at her.

Ellen believed that her father loved her, but this was more of an inference on Ellen's part than an experience of being actively accepted and supported by him. Her father never intervened on her behalf when her mother screamed at her and insulted her. He spent a lot of time at work; and when he was home, he tended to remain hidden behind his newspaper.

Ellen was an only child. There was no sibling with whom she could compare notes. Though she thought that her mother was selfish and cruel, Ellen concluded that there must be something wrong with her as a daughter for things to have turned out so badly between them. Especially, she had a deep sense that her mother's disappointment in her femininity—Ellen wasn't pretty enough; she didn't know how to behave properly; she was aggressive, hostile, and unladylike—must be valid. After all, her mother, despite all her faults, was a mature woman: she had gotten married and had a child. Ellen felt incapable of doing the same and believed that her mother must be right when she told Ellen she was inadequate.

Our work together centered on trying to understand the reasons for Ellen's inability to free herself from her mother's negative judgment. It was my impression that despite her significant criticisms of her mother, Ellen maintained a considerable and costly idealization of her mother, which lent credibility to the accusations with which her mother had bombarded her. As we went over Ellen's view of her childhood, it became increasingly clear that Ellen was powerfully motivated to avoid recognizing what, from her portrayal, seemed to be her mother's terribly hurtful narcissism. Ellen could tolerate the thought that her mother was abusive, even

that her mother hated her; but these perceptions implicitly assumed that her mother was significantly, if misguidedly, attached to Ellen. It was immeasurably harder for Ellen to consider that, to a significant extent, at any rate, her mother simply did not love her —that her mother found no difficulty in placing her own selfish preoccupations ahead of Ellen's needs. The kind of maternal interest, let alone concern for her daughter's welfare, that one might expect to find in a mother was apparently absent in Ellen's mother.

In order to cherish the idea that her mother was passionately, but ambivalently, involved with her, Ellen was obliged to find at least a measure of truth in the image of herself that she saw reflected in her mother's eyes; and the result was exorbitantly costly to Ellen's self-esteem. Our analysis of the problem allowed Ellen to engage in a profoundly painful mourning process. She had to relinquish her image of a turbulent and erratic, but loving and lovable mother. In its place, Ellen accepted the realization that her mother had, in crucial ways, failed to love her. Along with the loss, however, came the possibility for Ellen to construct a new, more positive, liberating image of herself.

Ellen began to date again. [Her self-confidence increased. She no longer avoided trying to find a relationship with a man, which was something she very much wanted. These changes led me to think we were on the right track.]

We had the opportunity to identify many of the ways her habitual expectations—her assumptions about who she was and how others would see her—sabotaged her social life with men. In her relationship with me, Ellen was afflicted by doubt. She worried that by encouraging her to think that she could be a desirable woman, I was engaging in wishful thinking, that I was selling her a bill of goods that made me feel more helpful and generous, but set her up for bitter disappointment. Alternatively, if I were silent for any time, Ellen would get a panicky feeling that I had lost interest, that I had disappeared, like her father behind a newspaper.

Eventually, Ellen met Howard, a kind and gentle, solid guy, who fell in love with her and let her know it. By now, the work she had done permitted Ellen to recognize, enjoy, and reciprocate

Howard's feelings. After a few months, they were spending virtually every night together. Howard's marriage had ended badly several years before, so that he was understandably cautious about rushing into a formal commitment; but everything pointed toward the two of them living together soon, and eventually marrying. [Again, Ellen's ability to enjoy a relationship with a man, not to sabotage it, confirmed our work, from my perspective.]

Ellen was in seventh heaven. She was extremely grateful to me. After two years of treatment, her dream, which she had come to believe was an impossible one, was now coming true. She could not believe it was happening. And that was the problem. Even though she had what she had always wanted, Ellen remained in the grip of a kind of hypochondria. She feared that she might develop a fatal illness that would cut her down on the eve of her greatest happiness. She made frequent visits to physicians, with morbid anxieties instigated by relatively trivial symptoms. Sometimes, she pressed her doctor to perform diagnostic tests that the doctor assured her were not necessary.

If not a physical disaster, Ellen feared, then some other kind of catastrophe would prevent her from being happy. She tortured herself with morbid concerns about Howard. Why hadn't he proposed yet? It must be that his traumatic marriage had left him incapable of entering into another long-term relationship. His love for her was cooling.

Because of these disaster fantasies, Ellen required a great deal of reassurance. Howard was willing to provide it, in a loving and patient way; but Ellen never stayed consoled for long. Her needs —not to say demands—went on unabated. There was a danger that, if this problem persisted, Ellen's anxiety about her relationship with Howard failing would turn into a self-fulfilling prophecy. [Now Ellen's distress returned in a new form. To me, this meant that either we had taken a wrong turn, or that something more needed to be learned.]

The question, for us, became: why couldn't Ellen believe in her good fortune? We had unveiled a number of motivations underlying Ellen's belief in her mother's critical view of her. The

work had proven extremely useful to Ellen in a variety of ways, but she still felt, she said, that she did not deserve to be happy. She was sure something terrible would happen and everything would be ruined. When I asked Ellen what she meant when she said she felt she didn't deserve to be happy, she answered that she felt guilty; but she found it hard to say, specifically, about what.

I encouraged Ellen to pursue her associations. She thought about how rageful she could become. She remembered times that she had literally wished her mother would die. Ellen speculated that she believed she had somehow caused her mother's fatal cancer. Maybe now she felt doomed to share her mother's fate. To me, it all sounded intellectual and formulaic. Ellen's memories of hating her mother, even wishing her dead, were certainly sincere; but the claims to remorse rang a bit hollow. Ellen knew very well that her mother had been abusive, and that her fury toward her mother had been understandable under the circumstances. The idea that she believed she had caused her mother's cancer seemed like psychologizing on Ellen's part. Most important of all, none of this alleged insight was accompanied by any alleviation of Ellen's unrealistic concerns, or by amelioration of her urgent, insatiable, and ultimately self-defeating need for reassurance. [Here is an obvious example of how analytic understanding that might otherwise have seemed valid and important was less than convincing to me because it was not accompanied by symptom relief.]

I began to get annoyed at Ellen. I experienced her as whining, which was unusual; generally, I felt very warmly toward her and sympathetic with her complaints. At first I chalked up my annoyance to frustration of my therapeutic zeal and analytic ambition, but then I realized there was more to it. There was something narcissistic about Ellen's suffering. She spoke a great deal about how guilty she felt, but essentially she was complaining about feeling guilty. Clearly, Ellen felt very sorry for herself. How guilty does someone really feel if she feels sorry for herself for feeling guilty? Ellen's implication was that her guilt feelings were an unmerited burden.

When I pointed this out to her, she got very hurt and angry. Now, not infrequently, Ellen would begin a session by telling me that she felt fragile and reluctant to talk, that she was concerned I would criticize her. She admonished me not to be too hard on her. Ellen conveyed that being with me was like being with her mother, that she was suffering in analysis just as she did in the rest of her life. At the same time, she was puzzled by her experience of me because she believed, from all her prior experience, that I was well intended toward her.

My irritation led me to an observation. Despite all her protests about how guilty she felt, Ellen had never mentioned anything that she actually regretted, concerning which at least some measure of guilt feelings might be realistic. She was certainly aware that her demands for reassurance from Howard and from me were unreasonable, but given their self-defeating nature, they were more a cause for anxiety than for guilt. I thought in particular about Ellen's relationship with Richard. Granted—that, too, had represented an extremely self-defeating step for Ellen; but hadn't it been harmful to Richard as well? As a college senior, she had taken up with a high school student and entered into an unsuccessful marriage with him. Didn't she have questions, in retrospect, about the morality of her actions? I'd heard quite a bit from Ellen about the wasted five years of her life and their traumatic effects; but she had never once expressed curiosity about what had happened, eventually, to Richard, let alone remorse about how she had gotten him involved in something that wasn't good for him.

I shared my thoughts with Ellen, and at first she had a hard time understanding what I was talking about. She claimed to feel very guilty about her marriage, but her elaborations of her sense of guilt kept sliding into regret about how wasteful and destructive the marriage had been for her. I pointed out to Ellen her difficulty thinking about how she had acted badly toward Richard, and suggested to her that her continuing feeling that she didn't deserve to be happy and her expectations of disaster might stem from an understanding, which she was reluctant to face, that she really had done some things that weren't very nice. While it was

true that she had often been a victim in life, it was also true that, at times, out of her desperation, she had victimized others.

[Clearly, here I brought an opinion of my own into the work. An analyst is constantly doing that in all his/her clinical activity, though usually less explicitly and conspicuously than at this particular moment—that's what we mean by the participation of the analyst's subjectivity in the intersubjective encounter that is clinical psychoanalysis. However, in illustrating the importance of using the patient's experience of therapeutic benefit as the outcome criterion for clinical analytic work, what I want to emphasize about this particular moment in Ellen's treatment is that the sustained lack of alleviation of her distress led me to the conclusion that we had to keep looking for something new and/or different that could be added to our understanding. Obviously, my intervention, besides being helpfully intended, was a criticism of Ellen that in part expressed my anger at her. Of course, an analyst's clinical activity always expresses the analyst's very personal motivations, often unconsciously. Therefore, the fact that an intervention is a "countertransference enactment" does not, in itself, indicate whether the intervention is useful or not, because enactment is an aspect of all interventions, good or bad.]

Ellen reacted to my intervention by being horrified about herself. For several sessions in a row, she lamented her treatment of Richard, castigated herself, and described complete pessimism about her future—she really was awful and did not deserve happiness. My impression was that Ellen was beating herself up in a plea for sympathy, in order to ward off genuine self-criticism, in the hope of being reassured by me. I told her so. [Here, as is often the case, we were at sea—I had a notion of what might be useful to pursue and I was pursuing it, but with trepidation because there was no symptomatic improvement to confirm the validity of the approach I was taking.]

That was toward the end of a session. What I said brought Ellen up short, and the hour concluded in silence. The next day, Ellen seemed sober and reflective. She announced that she had a confession to make. This was something about which she felt really

terrible, and something about which she had, in effect, lied to me. She knew very well that she had led me to assume that her marriage with Richard had never been consummated because of his immature failure to perform. That was not true. In fact, he had tried to penetrate her many times at the beginning of their relationship, but she had been unable to let him. Painfully and haltingly, Ellen described an unremitting vaginismus that had ultimately caused Richard to give up attempting to have sex with her. She knew, she said, that Richard's frustration and hurt had been an important reason for his drug use and failure in college. Ellen began to sob. He had taken up riding motorcycles, she told me, and a couple of times had been in terrible accidents. She had been so selfish and so bad for him.

Ellen spent a couple of weeks going over what her marriage had actually been like. She decided that she had been very screwed up to feel okay about taking advantage of Richard. He was really only a kid when she met him, and she should have restrained herself. She had been drowning, but the way she tried to save herself wasn't very nice. She considered trying to get in touch with Richard, to apologize and to find out how he was doing; but ultimately, she decided that it would likely be more disruptive than useful or kind.

She thought back to how hard it had been for her to admit that she had been destructively selfish toward Richard, when I first raised the idea. It put her in mind of a woman with whom she had felt very close some years ago, who had eventually said that she couldn't be friends any more because Ellen's requirements were just too high. At the time, Ellen had been very hurt and hadn't been able to figure out what her friend was talking about; but now she understood. Ellen remembered how entitled to sympathy she had felt in that relationship, how much attention she had expected. [These insights on Ellen's part impressed me as crucial and moving. They involved a radical change in her view of herself, past and present, which she explored with what seemed to be sincere, even profound emotion. Nonetheless, while I was encouraged, I was not able to feel reassured because there was no evidence that

Ellen's new understanding had produced significant symptomatic improvement.]

As she continued with these painful reflections, Ellen's attitude and behavior toward Howard altered. She began to be keenly aware of his loving patience, grateful for it, and worried about abusing it. More often now, when she became anxious, she would make the judgment that she was dealing with an irrational concern, and would try to set it aside on her own instead of asking Howard to reassure her. At the same time, as her misguided sense of entitlement diminished, her legitimate sense of entitlement grew. She acknowledged her sexual inhibitions and challenged them. At her initiative, she and Howard began to be more adventurous in ways they both enjoyed.

[In my view, obviously, now we could see changes that confirmed the validity of our latest work. Time went on, and Ellen continued to be able to participate more happily in her relationship with Howard. Eventually, she terminated her analysis. Ellen keeps me posted periodically. She and Howard got married. It has been several years now and things continue to go well for them. Ellen's susceptibility to unnecessary worrying has not disappeared completely, but it is relatively minimal; and when an exaggerated concern does crop up in her mind, she is usually able to deal with it constructively. All in all, with regard to increased satisfaction and decreased distress, "so far, so good"—which is the most we can say, and what we hope to say, about any clinical analysis.]

In conclusion, I will note that taking into account the intersubjectivity of the clinical analytic encounter calls into question the rationale for certain long-standing principles of analytic technique, e.g., analytic anonymity and analytic neutrality. However, more fundamentally important, in my estimation, is that an intersubjective perspective clearly exposes the methodological problem of circularity in clinical investigation—due to the fact that the analyst is a participant-observer—and the need to remedy that problem by organizing the clinical analytic situation, however imperfectly, toward empirical hypothesis testing. That remedy re-

quires identifying a dependent variable to be tracked, one that is disconnected from the analyst's theories.

I have suggested the patient's experience of therapeutic benefit as the outcome criterion of choice. When we establish the possibility for systematic empirical evaluation of psychoanalytic propositions, we can begin to adjudicate competing claims for all sorts of practices—including various forms of self-disclosure by the analyst, recommendations concerning how the analyst's personal opinions should and should not participate in the treatment, etc. Otherwise, our controversies concerning technique remain in the domain of rhetorical appeal and personal preference; and this undisciplined diversity with respect to our justifications for doing what we choose to do with patients obscures an underlying complementarity among ostensibly conflicting conceptions of the therapeutic action of clinical analysis.

## REFERENCE

Alexander, F. & French, T. M. (1946). *Psychoanalytic Therapy, Principles and Application.* New York: Ronald Press.

---

*388 Market Street, Suite 1010*
*San Francisco, CA 94111*

*e-mail: Odrenik@aol.com*

*Psychoanalytic Quarterly, LXXVI, 2007*

# A HOME FOR THE MIND

BY CHARLES SPEZZANO

*The author presents his view that the patient must find a home in the analyst's mind within which to tolerate the work of analysis. Analytic work and change are facilitated by the patient's experience of the analyst's mind as a place within which the patient exists as an internal object, toward whom the analyst relates with agency and freedom. To illustrate his way of working with the patient to accomplish this, the author presents case vignettes from his own practice and from the writing of Mitchell (1997, 2000) and Steiner (1994).*

*Therapeutic action* has usually implied that psychoanalysis gets inside us and does something. I will suggest that therapeutic action also involves the patient's getting inside psychoanalysis through a subjective experience of the mind of the analyst as a certain type of psychic environment (or home), as well as through an emotional experience and image of him-/herself as a presence in that mind. This might be viewed as the other side of the coin from an issue about which much has been written—that is, the emotional experience and image the patient has of the analyst as object within the patient's mind.

Further, I will try to distinguish the issue I focus on in this paper from the issue of the analyst's ability to contain anxieties pro-

---

Charles Spezzano is a Training and Supervising Analyst at the Psychoanalytic Institute of Northern California, San Francisco.

This paper was presented at San Francisco Center for Psychoanalysis on April 11, 2005.

jected by the patient or to create a safe space for the patient. I am specifically raising the need for the patient to experience the analyst's mind as a place within which the patient exists as an internal object—an internal object toward whom the analyst relates with agency and freedom. The patient then has a chance to form an unconscious identification not only with the analyst's interpreting function (Spezzano 2001), but also with the analyst's psychic agency and freedom. This identification emerges out of the patient's sense of the analyst's mind as a place where the patient and the analyst are related in a way that includes the analyst's thinking with agency and freedom about the patient.

In addition, however, the implied analytic goal of the patient's ending up with a freer mind has required analysts of various persuasions to respect patients' worries about what is happening to them in the mind of the analyst, so that the patient works toward more freedom of mind not only through unconscious identification, but also through the growing conviction of having a measure of autonomy as an object *in the mind of the analyst.*

I'll try to illustrate this point with examples from the writings of two analysts who are not ordinarily thought of as having much in common with each other: Mitchell (1997, 2000) and Steiner (1994).

## FINDING OR CREATING A HOME

To tolerate the kind of interpreting that psychoanalysis involves, the patient's mind must feel at home in the mind of the analyst. I mean this metaphor to refer to what I consider a third piece of the puzzle of the phenomenon we have come to call *projective identification.* Klein referred to this as a phantasy (i.e., an infantile fantasy operating unconsciously) about the locations of parts of selves and objects in psychic space. Bion added that it is a form of unconscious affective communication. I believe both those ideas rest on the reality that we live in the minds of others as well as our own. Others create representations of us as their internal objects, and we are aware of and impacted by this; projective identification is a fantasy about this reality.

Put another way, the patient's internal object representation of self-and-analyst will reflect the patient's imagining of a self-and-analyst living in the mind of the analyst. This image in the mind of the patient is a fantasy (although grounded in actual experiences within the transference-countertransference situation) about the analyst's fantasy of analyst-and-patient, and for interpretations to work from inside the patient—that is, to be mutative—the patient's fantasy must be one in which the analyst's mind is a free mind. In identification with the analyst's free mind, the patient can imagine taking in interpretations because they are not experienced as fixed and authoritative entities, but as things to be played with, as Winnicott (1971) and others have suggested.

For example, a 40-year-old, twice-divorced man is talking about whether he can trust his feeling that he wants to marry his current girlfriend. What comes to my mind and what I tell him about is a movie scene in which a man asks a woman to marry him. She asks, "Are you sure?" He replies quickly: "Absolutely"—pauses—and then says: "Well, you know, as sure as a guy like me can be about anything like that."

I could have said to the patient directly, "I have the impression you're worried not so much about this woman being or not being the right one, but about whether you can actually stay with it, with anybody, over a sustained period of time." But I said the other first, and then, after the patient affirmed that the worry was about himself, I phrased it in the second, more directly interpretive way.

In part, I do this because I have been persuaded that metaphor and analogy are the native language of the mind (Gibbs 1994). Also, I want patients to see that analytic interpretations neither appear magically in their final form, nor flow from psychoanalytic theory directly to them, but are products of a human mind that has been immersed in psychoanalysis, while not colonized by it. I think this helps create a context for the patient in which to set up a temporary home in the mind of the analyst, one that addresses the fundamental psychic homelessness to which we are all prone and which is one of our basic anxieties, but also one that allows for

a representation of self in relation to an object from which living interpretations come into one's own mind.

Religions and sacred traditions are the most familiar and longest running homes for the mind. People in every society have confronted the cosmos created by their religion as an immensely powerful reality outside their selves. Yet this reality addresses itself to their concerns (especially, their anxieties and suffering, and the anxieties and suffering of those to whom they are attached) and locates their lives in some ultimately meaningful order. According to sociologist Peter Berger and colleagues (Berger, Berger, and Kellner 1973), the sacred, among its other meanings, is understood as a defense against chaos. To experience oneself as symbolically having a place within the fundamental meaning system of the universe is to be protected against the threat of chaos—to be *contained,* as we might now say. Some Asian philosophies suggest that our natural home is our own concentration, and so this state of concentration, in my terms, becomes a place to which the mind can go.

In psychoanalysis, Money-Kyrle (1968) referred to this notion of a home for the mind when he suggested that we require a *psychic base.* This base, he suggested, should not be assumed to be the body-ego (which he appears to have believed was a common assumption among analysts in the 1960s). Instead, he argued, "the body-ego itself needs a home" (p. 695). The sense of being located somewhere is essential to avoid psychic homelessness and the disorientation that accompanies it. It is clinically important, Money-Kyrle concluded, that patients become oriented to their analysts as a home base where they can come to recognize which objects belong and which do not. I will try to take this notion further, as in the following account of an analytic hour.

A young woman, E, has been telling me about a new man in her life, F. In the session I recount here, she begins by saying that she might be losing interest, possibly concluding that she is "just not that into him." She says that he called her to say a woman he met a few years ago through an Internet dating site is coming to the area. F attempted to reassure the patient by saying that he and

this woman, G, had remained friends after their hopes for becoming a couple had not worked out. G happened to be coming to visit an ill father in a hospice near a vacation home that F owned with some friends, where he and the patient had been together. Not liking the woman to whom her father was married, G asked F if she could stay at this vacation house, and he agreed. He also plans to go there for a day over the weekend—but not to stay overnight, and will be there only as a friend.

My patient, E, then tells me that, as soon as she and F had finished their phone conversation, she immediately called her best friend and said: "I just got off the phone with F, and he told me that some chick he met on the Internet is coming here and they are spending the weekend at that vacation house he has." E's friend and E agreed that, obviously, E should dump F. But her point to me, as she put it, is that "I was totally lying. I'm such a bullshitter. And I do that much more than I tell you. Well, I don't know."

I respond by saying: "I recently read a little book by a philosopher at Princeton. Its title is *On Bullshit* [Frankfurt 2005]. You said that you were lying and that you are a bullshitter. This philosopher said he thought there was a difference. When lying, we talk with the purpose of conveying information, even though false information. When we bullshit, we really don't care that much about the information or whether it's true or false; we just want to create a conviction about something in the mind of someone else. I think that's what you do. You feel uncertain about F and you can't escape that, so you create a sense of conviction in your girlfriend's mind—a conviction that you should dump him. You hear her articulate that, and it's like another *you* is talking—one who is confident, angry, and certain, instead of confused, anxious, and ambivalent."

The patient then asks: "Are you making that up . . . about the philosophy book?"

I say, "You mean am I bullshitting you back?" She laughs. And I continue: "Well, that's part of how it works against you also, to use that way to escape your anxiety. You have to worry if the other

person is doing the same thing. So it adds to your uncertainty about knowing anything."

The patient responds by saying, "I hate feeling that way about F—that I don't know whether to get in deeper with him and make a mistake like I've done before, or bail out."

I say: "You leave out the option of sitting still with the uncertainty because, as you say, that gets you feeling more and more anxious. I think what you do is create a sense of certainty and conviction in the mind of another person by bullshitting, and then when you hear them say what you should do, it's like the real you is living in *their* mind, and *that you* knows exactly what to do. And so you feel much less anxious for a while."

She responds, "Yeah, for a while . . . a short while . . . and by the time I'm here, I feel crazy that I did that . . . I mean, made up that story."

I say, "Well . . . okay . . . so you tell me, and I think you look for signs of the opposite conviction—that you should feel committed to F and get in deeper with him. You move your self around from one person's mind to another's, and for a moment you feel at home in each one, like you're finding your real self there."

This exchange occurred in the seventh year of this woman's analysis, and I think she unconsciously chose to confess her bullshitting to me because she was getting ready to leave the home she had made in my mind for many years. She had gone back and forth between believing she had to be a good girl to stay and a bad girl to leave. Now she is considering being an uncertain woman who can try relationships with men, rather than being limited to immediately falling in or jumping out.

John Dunne (1972) described this process as "a phenomenon we might call 'passing over,' passing over from one culture to another, from one way of life to another, from one religion to another" (p. ix)—and, I might add, in analysis from one mind to another. According to Dunne, passing over leads to a return: "It is followed by an equal and opposite process we might call 'coming back,' coming back with new insight to the home of one's own mind" (p. ix).

In all such seeking for a psychic home, we must look for an external reality, outside both our embodied and internal selves. In analytic discourse, we juxtapose external reality with psychic reality. What we do not always make explicit, however, is the extent to which the reality that is external to each of our psychic realities is composed of the psychic realities of other people's minds. The mind of the patient searches for a home in the collective human psyche, and more immediately in the mind of the analyst. This has to be experienced by the patient *as a mind*—not only one that is able to interpret accurately, but also as one that can tolerate itself as subject to affects, ideas, or metaphors of uncertain origin, and free enough to risk expression of its unique way of unconsciously organizing experience. This is how we hope the patient's mind will work by the end of the analysis; we hope the patient's mind will become a free psychic space rather than a fear-dominated space.

The patient cannot, by contrast, become at home in a psychoanalytic theory that is separate from the mind of the person through whom that theory is applied. If the patient were actually to find her or his home in the theory itself, then that theory would be functioning as a secular religion. Psychoanalysis is not a secular religious theory precisely because it requires a personal encounter, and because, in this encounter, it is *one mind finding a home in another* that forms the foundation of the therapeutic action.

This agenda to create a home for the mind of the patient accounts for the fact that analysis is not, in practice, simply a process of sorting through clinical theories and picking the best one to utilize for each moment. We use theory, but it comes into play almost automatically because we use it as a psychic home—and, therefore, it can become something of a secular religion for us as analysts. For the moment, however, I will discuss theory simply as a psychic home in which we have each shaped what I once referred to as "a psychoanalytic unconscious . . . . The ideas that reach consciousness no longer reflect only [an analyst's] personal, familial, cultural, and linguistic meaning systems but also a psychoanalytic meaning system" (Spezzano 1993, p. 212).

Poland (1988) made a similar point when he wrote that the deepest level of therapeutic action is one at which the analysand not only utilizes new understandings in ways that show up in consistent changes in character and mental functioning, but also utilizes these new understandings without being aware of using them, or without having to think consciously of using them.

I think we go back and forth about the roles of insight versus internalization, or remembering versus breaking patterns, in catalyzing such change because the psychic space that each analyst provides for the patient to inhabit is a theoretically imbued, personal space—recognizably furnished with ideas from the collective knowledge of psychoanalysis, but also showing the idiosyncrasies of the individual analyst. This psychic space that each analyst provides must show the mind of the analyst to be free for the play of a full range of mental activities and contents—whether a scene from a novel or film, a joke, a sports metaphor, a detail about some experience—so long as it contains some understanding about the patient. Sometimes, I find that one of my own such associations is the best way I have to capture that understanding.

By way of another example, I will mention a patient whom I had been seeing five days a week for ten years. One Friday, she questions whether, like herself, I will be keeping the connection between us alive in my mind during an upcoming four-day break. I reply that, on the radio that morning, I heard a broadcaster say that the San Francisco Giants were no longer functioning as twenty-five people with twenty-five different things on their minds, but as a team. I add that, when you play on a team like this, you either have that experience or you don't; you cannot know it simply because someone else tells you it is true.

So I offer the patient what I find immediately in my mind. In retrospect, I see my hypothesis as the belief that, in revealing the presence in my mind of a third thing like a baseball comment, I was not only providing a catalyst for understanding the patient's dilemma in a new way, but I was also indicating that she was not alone in my mind with me—an anxiety that often terrified her, I thought, but about which she could not speak directly. Third

things, such as a metaphor imbued with something from the life of the analyst outside the sessions, are necessary to keep the mind of the analyst from seeming too much like a place inhabited *only* by the patient and the analyst—a destructive illusion that, I believe, an exclusive and direct emphasis on the transference-countertransference situation can inadvertently foster or sustain.

When we talk spontaneously, the patient gets to see the kind of place in which he or she is being invited to live for a while and do the work the patient has come to us to do. It is the kind of work that has been referred to (in translation of André 2004) with the delightful description, "to teach language to talk about you" (Zilkha 2005, p. 222). In any case, none of what enters consciousness in the analyst's mind should be ruled out for potential use solely because it frightens the analyst to imagine using it.

## THEN WHAT?

This provision of a home for the mind of the patient is, of course, only one part of therapeutic action. Another major part involves activities that might be described metaphorically as the mind of the patient unpacking itself—showing itself, being shown to itself by the analyst; finding abolished, dormant, undeveloped, repressed, and projected parts of a whole self; healing some damaged parts, taking in some new parts from the analyst. These activities are followed by the patient's leave taking, now that he or she is able to be a more emotionally alive presence in the world of other people.

The patient's mind has to feel at home in the mind of the analyst so that it can unpack itself, face its lifelong fears about standing naked (like Adam and Eve) in confusion, guilt, or shame, and use its experience of the analyst's mind as a home base from which to make more emotional contact with the world.

There are many ways to explain how all this happens. The way I find myself thinking about it is that the patient arrives with a cast of characters in mind. This team of characters forms, dictates, and limits what the patient imagines and expects to happen. As analysts, we ourselves arrive not only with our own internal cast of

characters, but also as a member of the psychoanalytic team. We recruit the patient to participate on this team—that is, we recruit him or her into our mind to play the analytic game, while the patient recruits the analyst to play characters from the patient's traveling ensemble, with the patient playing others.

This gives character analysis a new meaning in an object relational dimension of psychoanalysis: we analyze the characters the patient has created to represent experience. In so doing, we invite the patient to view them from the audience with us, to allow us to co-create new scripts for them, to introduce new characters, and to treat them as mutable creations, rather than as permanent residents of the patient's inner world. We make interpretations by telling the patient how we might view ourselves as actors, and then imagine how the audience sees us in the scene we are enacting. As a result, when the patient retires from the analytic team, his ensemble of inner characters has changed, offering new roles for him or her and new views of others.

The analyst is more able than other people to be helpful in the patient's conflicted effort to change because the analyst has immersed him- or herself in whatever training and studying to which each has been drawn, with the result of the analyst having *emotional and ideational muscle memory,* just as athletes have physical muscle memory. This metaphorical ideational and emotional muscle memory allows the analyst to do the following: to listen carefully, see things that would escape the attention of others, point to and interpret what is observed, contain bad feelings, tolerate being a bad object in someone's mind, make connections between things that are in the patient's mind so that new realizations can take place, and make all the other moves that have been reported as helpful in one clinical case or another—as well as to live with the sudden realization of having made an error and with the constant awareness of never being able to see all the possibilities.

Without the analyst's drawing on the power of the analytic community's accumulated knowledge and wisdom, the balance would be tilted too far toward analyst and patient uniting into a dyad that is untriangulated by any collective consciousness outside the dyad.

There is something in every one of us, I believe, that pulls for this collapsing of the analytic space into a closed dyadic system, in which whatever the two of us say is real and whatever we do is good. The analyst having become a certain kind of tool through which a collectively owned entity called *psychoanalysis* is applied helps keep this tendency in check.

On the other hand, the attempt to specify methodology too stereotypically and prescriptively throws off this balance in the other direction, leaving the analyst too united with the collectivity of analysts, like a parental couple with an overly excluded child. This gets us onto a particularly troublesome road that always ends in something like a parameter—which is a way of saying that we always use a specific method except when we do not, in which case we do all sorts of other things because we are, after all, trying to figure out how to help somebody do something that *they* are trying to do. That something is to end up, after analysis, living a life that has less frequent, less intense, and less disturbing anxiety, depression, shame, and guilt, and more frequent, more intense, and less disturbing excitement and pleasure than the individual would have experienced without the analysis.

## THE PATIENT'S ROLE

Freud had a realization about a crucial and universal human agenda: the attempt to use other minds to bring out and explore what is happening inside us, and also to use other minds to regulate or change what is happening inside us. The two agendas are not identical and can be in conflict.

Nonetheless, we are aware that there are biological/psychological processes constantly taking place inside us, which we have come to call *unconscious* mental or emotional activity. We become aware of the existence of these processes through their products or derivatives, which emerge into consciousness as feelings, images, thoughts, and dramatic enactments.

Just as uncomfortable and painful events in that aspect of ourselves we call *body* drive us to talk to others, especially physi-

cians, hoping to find out more about what is going on "in there" where we cannot see, anxiety and emotional pain drive us to communicate with others all our lives in attempts to find out more about what is going on "in there," and in attempts to change what goes on "in there" so that we will feel less anxiety and pain. We humans have done this in all our societies, and, at a certain point in history, the privilege and role of being the one to whom seekers of insight and change direct themselves was turned into a professional activity. Now that there are a group of us who do it full time (and exchange observations and ideas about it), many people choose to do it with us.

## INTERPRETING

The most distinguishing aspect of what we do is interpreting, but what makes interpretation stand out in psychoanalysis is not that we can prove it to have more mutative potential than anything else (such as internalization), but that it is a unique privilege granted to us by patients. It is the one thing we do that most draws upon the collective knowledge of the psychoanalytic community, and it is also the thing we do that is least likely to be done well by anyone else in the patient's life.

In granting us the privilege of interpreting to them, patients allow us to tell them that they don't know what they're talking about, don't mean what they think they mean, are revealing aspects of the workings of their own minds that they don't know they're revealing, that they want what they don't know they want, are afraid of things they don't know they are afraid of, or that they engage in certain forms of mental activity over and over—not for the reasons they think they do, but because doing so helps regulate their anxiety.

Mitchell (2000) reported the case of a woman who was painfully and confusedly conflicted about the role she wanted sexual excitement to play in a man's attraction to her. Mitchell told her: "I think people, including men, sometimes like you very much for reasons over which you have absolutely no control" (p. 73).

Viewed from one angle, he was teaching her (if not preaching to her) a piece of wisdom in which he believed. Viewed from another angle, however, this becomes an ingenious interpretation of a specific anxiety. The patient worried constantly about the uncontrollability of other people's affects when they interacted with her. Defensively fantasizing the existence of a strategy that would allow her to control others' affects, she was tortured by not being able to devise such a strategy.

In saying such things to patients, we accept and act on the privilege (granted by the patient) of challenging the patient's sense of being the only one inside his or her own mind—the only one in this psychic home—and we show evidence of the insidious way in which psychoanalysis becomes a shared home for the mind, an experiment in psychic communal living. Not surprisingly, then, in the literature of every psychoanalytic school, there is a recognition that, for analysis to succeed, the patient must be in a psychic position to receive interpretations (and to receive the Greek who bears this gift) into his or her mind. What I am adding here is that patients are in for the more startling and violently wrenching experience of finding themselves living in *our* minds as well—and we have to introduce each patient to the him/her who lives in our mind in a way that allows the patient to feel at home there as the character whom we interpret him/her to be.

In another illustrative example, Mitchell (1997) discussed a patient named George, who repeatedly told Mitchell about inner conflicts and his arguments with his wife over how much time he spent at home versus how much time he spent out with his friends. Mitchell reported his first intervention as an interpretation of internal conflict, in which he portrayed George as simultaneously wanting to turn over power to his wife, and defiantly and resentfully opposing the idea of her having such power.

Then Mitchell explained how George related to the interpretation (much as we might expect an author like Joseph or Faimberg to emphasize in a case report). George asked his analyst to summarize and repeat the interpretation, turning it into a thing he could bring to his wife. Mitchell made a somewhat ordinary

transference interpretation, one that might be made by an analyst of any persuasion: he told George that he was doing with the analyst what he had been complaining he did with his wife—turning the analyst into a powerful authority figure who had the real answers to life's conflicted dilemmas. George, in turn, became sulky and resentful, as if a powerful authority figure had taken control.

This is a type of clinical moment that Renik (1993) has described as inevitable. We might consider Mitchell's interpretation as the application of a widely shared psychoanalytic understanding to an aspect of the patient's long-standing psychic reality, but, inevitably, we get reminded (here by George himself) that all we have to offer is one interpretation of the patient's reality. George did not take the analyst's comment as a pure application of psychoanalytic knowledge about human nature; instead, he reacted as though he has discovered that, in Mitchell's mind, George's room had a sign on the door saying "Agent of His Own Suffering."

Mitchell then related that he backpedaled when George became upset and confused by the interpretation. Although I am not sure exactly what he meant by that, it reads as though he decided, through a fairly deliberate and reflective conscious process, to talk to George as if his thinking of the analyst as having the answers was understandable, and sort of okay for the moment—not the inherently problematic, transferential manifestation of what George did with his wife, as Mitchell had interpreted a moment before. One could argue that Mitchell was being relational—or, perhaps, even more specifically, self psychological—in realizing that he was involved in George's confusion and feeling of being criticized because his comment could, in fact, be taken as a critical one.

If, however, we back off from interpreting the transference because doing so seems to unusually upset a patient, and we see this approach as a relational one, then how should we classify Steiner's (1994) writing—from a contemporary Kleinian-Bionian perspective—that *he* backed off from making a transference interpretation to a patient who was upset at having had trouble reaching him by phone over the weekend (and then missed the Monday session)? Steiner noted that he had rejected this approach because

he thought the patient would experience such a patient-centered interpretation "as an attempt to make her responsible for her failure to get through" to him, and that "it would indicate [his] reluctance to accept responsibility for his contribution to the obstacles that stood in her way" (p. 412).

So, instead, Steiner offered what he called an analyst-centered interpretation, reporting: "I interpreted that she feared I was not able to create a setting where messages would get through to me." But he tried to attach a patient-centered transference interpretation to this by "adding that she also hinted that something theatrical was going on," and he "wondered if this was expressed in the way she tried to make contact" (p. 413).

The patient was silent, Steiner related, and then talked about her troubled relationship with her son, who got everyone in the house upset and then stormed out. Steiner considered making a transference interpretation of the kind Mitchell had offered to his patient George, in which he might tell her that, experiencing him as critical in his comment about theatricality, she had, through her silence, withdrawn in anger, just as her son had, but he did not think (just as Mitchell was forced to conclude about George) that "she would be able to take responsibility for her contribution to the difficulties in communication between [them]" (p. 413).

Steiner instead interpreted that the patient needed him "to accept the sense of helplessness when [his] patient disappears . . . [and] she needed [him] to cope with the feelings of her not coming to her session" (p. 414). When things had not gone as she had anticipated, the patient felt blamed and criticized. While Steiner thought that this patient tolerated such analyst-centered interpretations better, he was uncertain about these interpretations, in general, because he had found that patients sometimes experienced his interventions of this type as confessions that he was having trouble coping with them, and was admitting that he was anxious about tackling their difficulties and facing the consequences.

Steiner concluded—writing in much the same spirit as Renik (1993)—that "because of the propensity to be nudged into enactments with the patient, it is often impossible to understand ex-

actly what has been happening at the moment it is taking place" (Steiner 1994, p. 416).

What I am suggesting is that, faced with this difficulty in knowing what is happening at the moment, we can sometimes use what comes to mind—trusting, in a sense, that our unconscious has picked itself up out of the confusion and is offering a way for us to talk with the patient through metaphor and analogy. A part of us, as the analyst, has been momentarily depleted and confused, but has jump-started itself into a way of functioning that was dormant or missing and now is making itself available.

A month-long episode in which a patient found himself not having much to say in session after session, five days a week, and during which answers to questions I asked were met with unusually (for this patient) brief answers, came into the light of mutual understanding in this way. The 35-year-old, male patient, who had been coming to analytic sessions every weekday for about two years, said, with regard to the fact that he would miss the next day's session, "I won't be home until late." I replied: "Okay . . . then I won't wait up . . . do you have your key?"

When we resumed work, we were able to begin to understand the adolescent–parent scene we had been staging, with the patient, unconsciously, having taken a protective attitude (separating from a curious and potentially intrusive parent) toward what was going on in his life and in his mind.

There are also periods when an analysis might seem to be drifting aimlessly, but not on such a clearly defined dramatic-scene undercurrent as in the example just given. These might turn out to have been moments that reveal a place in the patient's unconscious world inhabited by "subjects with no history, living out existence in an alien body, which in turn is being surrounded by strange objects, in the middle of which objects other subjects can be encountered, equally enclosed in alien bodies, equally lacking a history" (Van den Berg 1972, p. 103).

These more overtly dreamlike moments of a patient's existence are also crucial targets of interpretation, but the interpretations that attend to them are more like dream fragments of the

analyst's that, I suspect, get intermingled with these dream fragments of the patient. My interventions, at this level, are not so much about the stories of selves and others that the patient tells (implicitly or explicitly), but are more likely to be structured along the lines of "As I listened to you, I found myself thinking . . ." Or I might play with a word or phrase used by the patient, as one might do if one were writing a poem.

It has been my experience that such an intervention, in turn, often helps the patient's mind become a home for exiled, half-formed, and missing parts of the self—parts such as the following: words and bodily sensations that previously have been treated as alien; psychic events in which the patient is not so much a clearly identifiable actor as grasping for an identity; and moments when others are not represented as whole persons but as ingredients in the patient's feeling states.

In other words, part of the process involves the analyst's unconscious creation—out of sensation and affect—of metaphorical accounts of selves and objects playing out characters in the mind. The analyst's countertransferential idiosyncrasies and emotional limitations are factors in how helpful he or she will be in creating, through these metaphorical translations, the kind of self and object characters that are hold-able in the mind of the analyst and the mind of the patient. Because this is a crucial part of analytic work, patients, understandably, worry about the analyst's mind.

## THE PATIENT'S WORRY ABOUT THE ANALYST'S MIND

And patients *should* worry about this factor in the very unusual treatment that psychoanalysis is, one in which they will be interpreted. Generally, people have little tolerance for being interpreted in any way on an uninvited basis, but they invite us to carry out this procedure that is potentially, if not inherently, violent toward them, and they often even allow us to speculate, if only implicitly, about things that are wrong (at least, colloquially speaking) with them.

Given this, and given that our minds are the tools through which psychoanalysis is applied to each patient in clinical work, it is inevitable that patients will worry if there may be something wrong with us that is interfering with, and will continue to interfere with, their getting what they need from treatment. This creates tension in clinical work, the amount of which varies with the general level of concern each patient has about living, even for an hour, in another mind.

I believe that patients should worry about our minds, among other reasons, because these analytic minds are the source of fantasies, even if theoretically imbued ones, that the analyst inevitably creates to supply "a link that has never existed" (p. 41), as Faimberg (2005) put it. I would put it this way: The analyst imagines the link left missing by trauma. As the potential source of replacements for such links, which might very well be taken in and installed by the patient, the mind of the analyst should be of great concern to the patient.

Some labels, such as *thin-skinned narcissist* and *borderline personality,* have arisen at least in part, I believe, as responses to our discomfort at patients' pursuing these concerns by becoming annoyed with us, or by becoming demanding, desperate, or attacking. Every school of analysis must deal with this dimension of the work—that is, moments when the patient's anxious concerns focus more on what we are thinking, feeling, or doing than on what *they* are—clinical moments that we saw Steiner and Mitchell improvising methods to deal with.

What Steiner (1994) and Mitchell (1997, 2000) did in responding to their patients are just two of many examples that can be found in the literature of every school of analysis, where the analyst takes up the patient's worry that there is something wrong with the mind of the analyst. There are, of course, many imperfections, idiosyncrasies, and developmental scars in the mind of every analyst. My sense is that extended confessions about these are only rarely helpful to the patient. However, taking seriously the patient's worry that something is wrong with the session, the relationship, or the analyst's mind is an important element of therapeutic action,

at least in part because it allows the patient to move around the co-inhabited psychological space with less fear of bumping into mysterious and dangerous things in a dark room.

And this is a special worry for patients who will have to look in the analyst's mind for needed but missing or damaged-beyond-repair parts of their own minds. Freud (1911) essentially said that not everything missing from consciousness exists as one of those things in the unconscious. Sometimes, things are missing from consciousness because something has been abolished internally. Needed forms of libido, aggression, and narcissism may be missing. When they appear in the analyst's mind, they are often alien and terrifying, and are almost always initially confusing for the patient. The patient might have the fantasy of having put it there. Whether or not the patient has this fantasy (and I do not think every patient always does), what appears in the mind of the analyst, as Freud suggested, is simply a mental function or content that is available to the analyst, but not to the patient. The disturbance caused in the patient by its appearance is often due to its being foreign to the patient.

Certain patients, for example, are plagued by the idea that they represent a type of character in the human drama who is scripted to get nothing satisfying from life, to live without real love, and to fight off pain and anxiety alone. The underlying, haunting belief is that they are missing their own love (as opposed to missing the sense of being loved). They exist outside the play of Eros through which human teams are bonded. In this gripping fantasy, patients have access only to power as a way of relating. This power is wielded in the analysis by the demand to be let in on the analyst's team, and the patient's evidence that he or she is being included or excluded is particular to each case. Separations of any kind are often key evidence that the analyst's real team is playing elsewhere, and the patient then becomes the excluded third of the triangle and may demand specific counterevidence.

One aim of the psychoanalytic profession might be to help people better tolerate the anxiety and pain of being on the human team. Living with us, in the jointly created psychological home we

call an analysis, our patients have the aim of gaining a special attribute that our elementary school teachers used to label "plays well with others," and that Winnicott elaborated into something along the lines of "plays well with one's own affects."

We analysts, too, have our aims. A key aim we have as a professional team is to investigate the unconscious dimensions of human psychology. Sometimes we play well with each other, but, as is true of our patients, we are frequently unable to sustain a sense of being drawn together in an Eros-driven union, and instead experience each other as trying to gain power and control over that thing of Freud's called psychoanalysis.

## REFERENCES

André, J. (2004). *L'imprévu en séance.* Paris: Gallimard.

Berger, P., Berger, B. & Kellner, H. (1973). *The Homeless Mind.* New York: Random House.

Dunne, J. (1972). *The Way of All the Earth.* New York: Macmillan.

Faimberg, H. (2005). *The Telescoping of Generations.* London/New York: Routledge.

Frankfurt, H. (2005). *On Bullshit.* Princeton, NJ: Princeton Univ. Press.

Freud, S. (1911). Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides). *S. E.,* 12.

Gibbs, R. (1994). *The Poetics of Mind: Figurative Thought, Language, and Understanding.* New York: Cambridge Univ. Press.

Mitchell, S. (1997). *Influence and Autonomy.* Hillsdale, NJ: Analytic Press.

——— (2000). *Relationality: From Attachment to Intersubjectivity.* Hillsdale, NJ: Analytic Press.

Money-Kyrle, R. E. (1968). Cognitive development. *Int. J. Psychoanal.,* 49: 691-698.

Poland, W. S. (1988). Insight and the analytic dyad. *Psychoanal. Q.,* 57:341-369.

Renik, O. (1993). Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanal. Q.,* 62:553-571.

Spezzano, C. (1993). *Affect in Psychoanalysis: A Clinical Synthesis.* Hillsdale, NJ: Analytic Press.

——— (2001). How is the analyst supposed to know? Gathering evidence for interpretations. *Contemp. Psychoanal.,* 37:551-570.

Steiner, J. (1994). Patient-centered and analyst-centered interpretations: some implications of containment and countertransference. *Psychoanal. Inquiry,* 14:406–422.

Van den Berg, J. H. (1972). *A Different Existence.* Pittsburgh, PA: Duquesne Univ. Press.

Winnicott, D. W. (1971). *Playing and Reality.* New York: Basic Books.

Zilkha, N. (2005). [Review of] *L'imprévu en séance,* by Jacques André. *Int. J. Psychoanal.,* 86:222-226.

---

*2252 Fillmore Street*
*San Francisco, CA 94115*

*e-mail: cjspezzano@gmail.com*

*Psychoanalytic Quarterly, LXXVI, 2007*

# THE CONCEPT OF THERAPEUTIC ACTION TODAY: LIGHTS AND SHADOWS OF PLURALISM

BY RICARDO BERNARDI

The eight position papers published here in *The Psychoanalytic Quarterly's* 2007 monograph offer a picture of the main ideas on therapeutic action present in our discipline today, reflecting the pluralism of theoretical and technical ideas that exist in modern-day psychoanalysis. These ideas produce a double effect on the reader. On one hand, we have a feeling of richness and creativity regarding the variety of ideas, but on the other, this wide variability can promote more unsettling reflections in reference to the difficulty of comparing different approaches, and uncertainty about the possibility of establishing shared criteria of evidence upon which various opinions can be based. This is a problem I will discuss in more detail at the end of my commentary.

Some convergence points and preoccupations are common to the different authors in this issue, such as the role that the relationship between the analyst and the patient plays in therapeutic change, the way in which something new arises in the analytic process, and the desire to deepen knowledge within a certain perspective rather than comparing or discussing other positions. In reference to the analyst–patient relationship, even though different points of view are represented, all the authors here consider it a crucial point to be discussed in relation to therapeutic change. Eizirik highlights the importance of this topic in many countries of Latin America,

---

Ricardo Bernardi is a member of the Uruguayan Psychoanalytic Association and a Professor in the School of Medicine, National University of Uruguay.

where the role of the transferential-countertransferential relationship was already prioritized halfway through the last century. Spezzano points out the intersubjective depth of the phenomenon that arises in the therapeutic process: the "patient's mind must feel at home in the mind of the analyst" (p. 1564). Aisenstein, for her part, draws attention to the fact that psychoanalytic work implies elucidating two "intertwined" discourses (p. 1455).

I do not, however, think it is possible to go much beyond this point in finding common theoretical or technical formulations among the different authors; Abend's observation on one aspect of therapeutic action is in fact valid in a broader sense: "The student of mainstream analytic theory can observe a spectrum of opinion about the importance of the relationship as a therapeutic influence" (p. 1430). He points out that a critical revision is necessary, clarifying what each position considers *therapeutic* in the relationship and "making every effort to verify any formulation about the patient" (p. 1438).

The appearance of something new in analysis is another topic to which various authors refer. Indeed, as was pointed out by Alexander and French (1946) many years ago, analysis is generally considered a source of new experiences. In reference to this, Newman says: "each of the new schools under the self-model umbrella is attempting to find ways . . . to engender in patients the hope and confidence that a new developmental experience is possible" (p. 1543). And the topic of the appearance of something new is also approached from other theoretical perspectives; Aisenstein, in quoting Green, points out that: "transference, in certain cases . . . means bringing up-to-date rather than recollection" and that "the analysand does not see in it a return of the past; . . . he sees it as a new phenomenon that can be explained in and of itself" (Aisenstein, p. 1450). Abend notes that, according to Loewald, "the analytic interaction does more than discover hidden meanings . . . ; it actually helps to create new meanings in the mental life of the analysand" (p. 1427). Here in the Río de la Plata, there has also been a strong trend to highlight the fact that analysis creates a new present constituted in a particular moment in the session, with contri-

butions made by both members of the analytic dyad (see, for example, Baranger and Baranger 1961; Berenstein and Puget 1997).

A third aspect that can be observed in the eight essays is each author's interest in keeping within the boundaries of his or her theoretical perspective, recording developments and showing their theoretical and technical potential. The mechanisms through which therapeutic action may act or have effects are presented in relation to a global vision of the theoretical frame that enriches the exposition. In some cases, an establishment of bridges with neighboring approaches is attempted (for example, between Winnicott's ideas and those of self psychology), but without the aspiration of constructing an open dialogue that would include a discussion of the variety of existing psychoanalytic positions. There is no attempt to take the discussion to the more general and abstract premises of each approach; instead, something we might call "minitheories"—of a more personal character and closer to experience[1]—are favored.

I think this is an encouraging sign that can facilitate future dialogue among the different approaches. Almost four decades ago, George Klein (1976) in North America and José Bleger (1973) in Buenos Aires both proposed (although speaking from very different theoretical premises) the development of a psychoanalysis that is closer to the clinical experience, or, as Bleger put it, closer to the *drama* of human existence. By this means, a door is opened to facilitate the personal constructions of each analyst—a point mentioned in this issue by Aisenstein, and one that led Sandler (1983) to speak of the "private" or "implicit" theories of each analyst, differentiating them from "official" or "public" ones.

The points highlighted in these essays (such as more critical attention to the implications of the analyst's function in the therapeutic process, a growing interest in understanding the ways by which something new arises in analysis, a greater freedom to express personal ideas over divisions between theoretical schools of

[1] Spezzano says that "we analyze the characters the patient has created to represent experience" (p. 1572).

thought) represent current tendencies that favor the progress and continuing development of psychoanalysis. Nevertheless, all these papers also manifest some of the problems that our discipline has not yet solved, and that I believe hinder greater progress in the conception of therapeutic action. These problems have a methodological and epistemological origin, and are expressed as sometimes paradoxical affirmations referring to therapeutic change and goals in analysis.

Paradoxically, it is sustained that psychoanalysis can be presented as a universal method whose orthodox application is uniquely desirable for every patient because it differentiates itself from all other forms of psychotherapy, in the same way that gold can be distinguished from copper; but, at the same time, psychoanalysis is called upon to adjust itself to best meet the needs of each individual patient. In other words, while the interpretive work is expected to develop greater creative flexibility in order to be adaptable to each individual patient, it is not advisable that this flexibility be applied when introducing technical modifications regarding different kinds of patients, problems, or situations.[2] This paradox is connected to a similar one related to the goals of analytic treatment, which was pointed out by Wallerstein (1965):

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

This paradox becomes even more striking when it is put forth that, in spite of the magnitude of the expected change, there are no tools available to confirm that change, which ultimately escapes the possibilities of objective evaluation or observation.

[2] Technical modifications, such as the introduction of parameters, are considered a limitation and not a sign of enriching growth in psychoanalysis, even as the field is confronted with a diversity of clinical and theoretical challenges.

The current theoretical and technical pluralism, which has an enriching aspect insofar as it reduces tendencies toward dogmatism, can also have a dark and problematic side if an adequate dialogue is not set up among the various approaches. In fact, it is not easy to establish, in an unambiguous manner, to what extent the different approaches coincide, complement, or contradict each other, or if they address different problems that originate from premises that are also different, therefore situating themselves in a dimension of noncommensurability due to a lack of semantic congruence and logical coherence amongst themselves. I remember that this difficulty surprised me the first time that I tried, many years ago, to systematically compare the main psychoanalytic theories present in my own social and professional milieu (Bernardi 1989).

Can we accurately state that the different technical and theoretical approaches are in fact different ways of reaching the same therapeutic objectives? Let us examine, for example, the similarities Lander proposes between the ideas of Bion and Lacan. Certainly, we can appreciate the analogies or confluences that Lander points out, but if we pay close attention to the nature of the concepts of Lacanian and Bionian theory, we encounter problems of logical incompatibility. For example, while in Bion the differentiation of internal/external is necessary (as can be seen in the concepts of container/contained, projective identification, evacuation, etc.), in Lacan, there is an expressed intention to construct a theory that disregards this distinction, which is not relevant for understanding unconscious signifiers. It is for this reason that the geometric figure known as the Moebius strip[3] is seen as a model to conceive a space with no inside-outside.

Can we say, in consequence, that we are confronted with contradictory points of view? Apparently, we can, but this need not hinder us from considering the possibility of using concepts from both theories clinically in a complementary manner. How is this

[3] The Moebius strip is a topological figure, formed by twisting a strip before joining its ends together; it seems to have two sides, but in fact has only one, thus subverting our representation of Euclidian space.

understandable? In my opinion, psychoanalytic concepts, as Sandler (1983) points out, tend to be used in an elastic manner, extending their meaning spaces beyond their original meanings. In this way, different versions of fundamental psychoanalytic concepts (e.g., the ego, the Oedipus complex, etc.) can be used conjunctly with no apparent contradiction, since this elasticity allows stress to be put on one or another aspect of the meaning. But, as Sandler points out, elasticity has a limit; there comes a point when it is necessary to acknowledge the fact that that there are two indeed different concepts, even if they sometimes use the same vocabulary.

Inversely, similar clinical experiences can be theorized in a different, sometimes apparently irreconcilable manner. This is what Aisenstein highlights when she says: "it has happened that I have felt myself to be in very close agreement with the clinical approach discussed by a colleague for whose theoretical positions I could feel only disapproval" (p. 1448). What this proves is that the relationship between codified knowledge (I use this term in the Polanyi [1969] sense) and our practical know-how is too lax. I agree with Spezzano when he quotes Steiner in saying that we cannot always "understand exactly what has been happening [in the consulting room]" (pp. 1577-1578).

We cannot help asking ourselves in what ways these different models of psychoanalytic process affect the results of analysis. A reassuring conclusion is that patients show improvement in all variations of psychoanalysis, even when their analysts play the analytic game differently (to use Spezzano's metaphor). To what extent this is actually true is a question to be addressed by empirical research, but, from a theoretical point of view, this possibility poses new questions and problems that seem difficult to resolve.

If different models of the analytic process yield similar results, then it is necessary to ask ourselves: Which are the effective factors that explain therapeutic action? Are they common ingredients that are present in different models? What is the role of the specific factors characteristic of each psychoanalytic approach?

A second problem is the possibility of analyses that produce negative results. We know that psychoanalysis (like any other effec-

tive treatment) can have iatrogenic effects when conducted in the wrong way or when the patient does not respond in the expected manner. Early on, Freud (1932) indicated this possibility when he talked about the negative therapeutic reaction. This is comprehensible when we remember that a lancet's sharp edge can cure when it cuts, but it can also cause harm. In addition to the above-mentioned problem of the semantic and logical incompatibility of different psychoanalytic models, there is a practical aspect that cannot be ignored, for psychoanalytic models propose not only a way of working, but they also anticipate negative results when certain technical indications are not respected. Hinshelwood, for instance, points out that there is often a view of Kleinian psychoanalysts as potentially damaging their patients by "relentlessly interpreting a malign form of aggressiveness" (p. 1496). He adds:

> It may be that Kleinians do not always consider the possibility of frustration as a source of destructiveness when making an interpretation; and, conversely, it must be said that other analysts may not always check the possibility of primary destructiveness as a source of aggression when formulating their interpretations. [Hinshelwood, p. 1496]

From Hinshelwood's perspective, not interpreting the patient's envy favors the process of "no change" and of disintegration. We know that the ways in which we interpret aggression vary a great deal within the analytic community. The differences in other technical methods are equally pronounced (for example, Aisenstein points out differences in the approaches of Joseph and de M'Uzan). However—and this is the point to which I would like to draw attention—we lack reports that speak of negative, or even different, effects on the treatment when comparing analysts who are affiliated with different approaches. This should cause us to doubt either the correctness of our predictions or the accuracy of our reports, and should oblige us to review our criteria of evidence.

In my opinion, trying to identify and evaluate therapeutic change exclusively through the application of ideal models of the analytic process leads us to a dead end on a methodological and

epistemological level. I agree with Renik when he states that a sole subjective conviction is not enough to assert the therapeutic effectiveness of psychoanalysis; he points out the problem of circularity in clinical analysis and "the need to establish outcome criteria for clinical analysis that are independent of psychoanalytic theory" (p. 1550). Dyadic truths constructed between the patient and analyst, which play a central role in the analytic process with each individual patient, prove to be insufficient to support one or the other hypothesis that exists in modern-day psychoanalysis.

From an epistemological standpoint, we can say that, in psychoanalysis today, we are confronted by the repeated usage of enumerative inductivism in the context of a much smaller usage of eliminative, inductive reasoning. The clinical vignettes we find in psychoanalytic literature usually show situations that confirm or illustrate the author's theoretical hypothesis; it is less frequent to find that they are used to discard a hypothesis or decide among alternative ones. It is also not common to find systematic reviews of past literature that allow alternative hypotheses to unfold and to be presented in a more operationalized way, enabling clinical or extraclinical evidence to be presented in support or negation of them. In consequence, there is a tendency toward a rhetorical-persuasive argumentative style that favors the dissemination and incorporation of new ideas, but does not facilitate critical discussion of them.

The problem, then, becomes one of identifying the kind of evidence that supports our ideas about therapeutic action. I would like to comment on some possible answers to this question that emerge in the eight essays in this issue.

From Aisenstein's perspective, the effectiveness of psychoanalysis is not up for discussion, and it is not necessary or possible to search for evidence other than that arising from clinical practice: "I see therapeutic action as an indisputable truth, and yet our view of therapeutic action can only be a subjective one. We do not possess the tools for measuring how the patient's field of thought has changed" (p. 1458); she adds, "I am among those who think that no theory of therapeutic action can be proved, which is why I re-

main skeptical about research in the field of psychoanalysis that passes itself off as 'empirical'" (p. 1447).

For Renik, on the other hand, the problem is how to go beyond the methodological problem of circularity in clinical investigation. This is why he proposes to "remedy that problem by organizing the clinical analytic situation, however imperfectly, toward empirical hypothesis testing. That remedy requires identifying a dependent variable to be tracked, one that is disconnected from the analyst's theories" (pp. 1561-1562). These variables are not process variables, but outcome variables: that the patients "feel more satisfaction and less distress in their lives" (p. 1547). He considers that an intersubjective perspective offers "an increased appreciation of the epistemology of the clinical analytic encounter" (p. 1549).

How, then, can we combine a hermeneutic approach with an empirical one? Or, in other words, how can we give greater validity to the psychoanalytic understanding of therapeutic action, without a loss of the subjective and intersubjective nature of psychoanalysis?

Some authors turn—and rightly so, in my opinion—to the concept of triangulation. Spezzano says: "Without the analyst's drawing on the power of the analytic community's accumulated knowledge and wisdom, the balance would be tilted too far toward analyst and patient uniting into a dyad that is untriangulated by any collective consciousness outside the dyad" (p. 1572). And Hinshelwood affirms:

> A triangulation process is then established: if the analyst's experience of the patient and the patient's material coincide in some way, we can feel confident that what is common to both will represent something of the patient's transference. Or, at the very least, this is a likely enough circumstance to allow us to venture an interpretation to see if it "works." [p. 1488]

The above quotation introduces the need for a temporal perspective. It has been stated that the main criterion of evidence that an analyst should pay attention to is the effect that an intervention

produces in the analysand and his or her evaluation (conscious and, above all, unconscious) of the treatment, a standpoint defended by Etchegoyen (1999).

Both Eizirik and Renik contribute useful clinical material to better illustrate the nature of the triangulation that they see occurring in therapeutic action. Eizirik exposes his preoccupation over a patient who believed she could end analysis without having sufficiently analyzed her needs and regressive defenses. According to Eizirik, the analyst's neutrality does not mean failing to acknowledge that the analyst is conditioned by his or her countertransference, theories, personality, and the external context; all these factors influence the analyst's vision of the patient. The triangulation proposed by Eizirik, following in the steps of Faimberg, is *listening to listening:* "By listening to the patient's reassignments of meaning to his interpretation, the analyst can discover the patient's unconscious identifications and, together with the patient, thereby facilitate the process of psychic change" (Eizirik, p. 1470). In this way, the reinterpretation that the patient makes of the analyst's interpretation becomes a part of the analytic process.

Renik maintains that if the analyst aims at specifically psychoanalytic goals arising from psychoanalytic theory, he or she becomes an authority not only in terms of that theory, but also an authority in the life of the patient. He says: "Patients usually seek psychoanalytic treatment with what is at heart a simple agenda: they want to feel more satisfaction and less distress in their lives" (p. 1547).[4] This is, in his opinion, "the only outcome criterion by which the success of analytic work can be judged" (p. 1551). To avoid the problem of circularity in clinical investigation, "psychoanalytic propositions can be tested by measuring a dependent variable: valid insights are ones that produce enduring therapeutic benefit; useful analytic techniques are ones that produce valid insights" (p. 1551).

In comparing Eizirik's ideas with Renik's, we note that, while Renik's approach aims at changes made on a manifest level (that

[4] Freud (1916-1917) summarized the practical achievements of treatment using two words: the capacity for *enjoyment* and *efficiency* (p. 457).

the patient will be able to experience more satisfaction and less distress), Eizirik refers to *unconscious* changes. However, I think this distinction is artificial. Let us observe the way in which Eizirik reconstructs the patient's unconscious thoughts:

> You [the analyst] are blind to what really makes me sick, anxious, desperate: it is feeling like a motherless child; I cannot tolerate it . . . . This is something I have always felt, and I do not know whether someday I will be able to live with it, without using so many defenses. [p. 1475]

If we compare this formulation with Renik's, we see the differences between them start to fade. Eizirik would agree that the preconscious- or unconscious-level changes he describes will promote a greater well-being and emotional richness in the patient's life. Renik would probably say that the changes he points out on a descriptive level are the effects of analytic work carried out at a preconscious or unconscious level. Moreover, in regard to the process that led to the changes in Eizirik's patient, it would be extremely interesting to study the role of the intersubjective phenomena that took place when the analyst engaged in a sort of argument with the patient, as though they were enacting the scene of an "arguing couple" (p. 1474).[5] It is likely, in my opinion, that this situation constituted a significant moment for the patient (a *now moment,* using the terminology of Stern et al. [1998])—one that favored an encounter with the patient on a more profound and conflicted level and that consequently led to the formation of transferential-countertransferential knots.

My point is that, in the essays published here, we find an opening to the triangulation viewpoint of therapeutic action and the treatment methods that follow from that viewpoint, which it would be beneficial to develop further. The triangulation views described in these papers are useful; however, they have the limitation of being based exclusively on the treating analyst's perspective and on

[5] To further investigate such phenomena, it would be more useful to employ the single-case research methodology, which implies a systematic study of the material, than the more typical descriptive vignettes.

the fragments of the sessions that he or she chooses to relate. In other words, there is a narrative in which *the patient is narrated* and the analyst is *the author of the narration.*

Is there any reason to limit our thinking about forms of triangulation that can come up within these boundaries? The suppositions that might lead to the limiting of the triangulation viewpoint are not, in my opinion, sustainable, since they tend to favor methodological and conceptual isolation in psychoanalysis. These suppositions are that:

(1) The analyst is the person who is in the best position to determine what the patient has obtained from analysis.

(2) The fragments selected by the analyst are the most significant ones to an understanding of the analytic process.

(3) The hypotheses that arise from the analyst's theoretical perspective are the only ones relevant to the comprehension of the process.

(4) The only valid psychoanalytic studies are those based on the analytic clinical method, and any other methodological approach to research has nothing useful to contribute.

These suppositions do not coincide with those of social sciences or science in general, which advise that triangulation procedures be applied as amply as possible, including the use of different kinds of data,[6] researchers,[7] theories,[8] and methodologies. It is interesting to note that the therapeutic changes pointed out by the different authors in this issue, including the ones who are more

[6] That is, data from analysts, patients, and significant third parties.

[7] From a methodological perspective, it is best that the person involved in the investigation is not the same person involved in the treatment. Moreover, Bleger (1973, p. 343) pointed out that the conditions of psychoanalysis do not favor an evaluation of the cure, precisely because the psychoanalytic method has led the analyst to concentrate on what he or she could not modify, as well as on the transference, and not on a global evaluation of the patient.

[8] It has been found that even empirical outcome studies show results that favor the psychotherapy preferred by researchers who conduct the study (Lam-

skeptical of empirical investigation, include modifications in patients' lives that can be studied by different investigators, using different types of data, hypotheses, and methodologies.[9] In fact, these studies and other, similar ones form part of the current research being conducted in the psychoanalytic field.

I would like to give an example that illustrates the way in which systematic empirical investigation can complement the triangulation concept discussed by Eizirik and Renik. As mentioned earlier, Eizirik describes in more theoretical terms what Renik describes in a more descriptive way when the latter refers to the possibility of the patient's feeling more satisfaction and less distress. These formulations have the inconvenience of being too general and nonspecific.

Among the multiple kinds of empirical research being conducted in the field, I would like to draw attention to one project that I find relevant to this situation: Staats, Biskup, and Leichsenring (1999) have developed a method, "Problems and Aims in Therapy" (PATH), designed to evaluate the way in which problems and goals are established by the patient in psychoanalytic therapy; these vary widely, both qualitatively and quantitatively.[10] This study can be complemented by another research method, be it a quan-

---

bert 2004, p. 808). The strength of the influence both of the theories and the personal context is greater when the investigator gives opinions on his or her own treatments.

[9] I agree with Aisenstein that certain important aspects of psychic change can be difficult to measure directly as changes in the area of thought. But these changes relate to other changes that can more easily be operationalized and evaluated through different methodologies (for example, other changes mentioned by Aisenstein: "the heightening and improvement of psychic functioning" or the "capacity to accept and cope with the conflicts inherent in life," p. 1447).

[10] In this study, an investigator—not the treating analyst—asks the patient to give a brief description of the main problem(s) that led him or her to seek help at the beginning of treatment and the goals he or she would like to achieve. Over the course of treatment, the patient is then periodically asked to describe to what extent these goals have been achieved and what new objectives may have come into being. The patient's answers make possible a qualitative study of the changes in goals produced during the treatment, and also the evaluation in quantitative terms of the effectiveness of analysis, from the patient's perspective, in relation to the problems that the patient has specified.

titative measure of outcome (using standardized tools), or a qualitative result obtained by using different methodologies to study the patient's narrative in sessions, or by ad hoc interviews or follow-up studies.

No investigative method can put forward the whole truth, obviously, and even less so if it is applied in an isolated manner. Allowing into the study the possibility of triangulation increases the number of pieces of the puzzle that we have to work with, which increases our comprehension of the problem and more fully reveals its complexity.

In summary, even though the papers I have commented upon show us the development of our view of therapeutic action principally from within the main psychoanalytic approaches, we can also find signs that indicate more global psychoanalytic changes in new directions. It is possible to perceive a greater freedom to utilize the implicit personal knowledge of the individual analyst (the *"transferential-countertransferential, theoretical-clinical magma"* that Aisenstein talks about [p. 1448, italics in original]), incorporating clinical experience into technique in a creative manner. The commentaries on clinical material from different perspectives enable us to gain a better knowledge of the changes that analysis produces, and at the same time to better understand the processes that lead to these changes.[11]

I have hopes that this road will perhaps lead us to formulate questions about therapeutic action that are more modest, from which we may reach more circumscribed insights on what works with which patient under which circumstances, and to the use of more limited "minitheories." For when these questions and insights are scaled back slightly, they will allow psychoanalysis to proceed on the basis of stronger arguments and more shared criteria of evidence.

[11] To understand therapeutic action implies knowing the means by which psychoanalysis promotes patient change. Bleger (1973) proposed "to start from the effects or results of the analysis to deduce the goals and means, and not starting from a previous formulation used in a normative way" (p. 326, my translation).

REFERENCES

Alexander, F. & French, T. M. (1946). *Psychoanalytic Therapy, Principles, and Application*. New York: Ronald Press.

Baranger, M. & Baranger, W. (1961). La situación analitica como campo dinámico. *Revista Uruguaya de Psicoanálisis,* 4:3-54.

Berenstein, I. & Puget, J. (1997). *Lo vincular: clinica y técnica psicoanalítica.* Buenos Aires, Argentina: Paidós.

Bernardi, R. (1989). The role of paradigmatic determinants in psychoanalytic understanding. *Int. J. Psychoanal.,* 70:341-357.

Bleger, J. (1973). Criterios de curación y objetivos del psicoanálisis. *Revista de Psicoanálisis,* 30:317-350.

Etchegoyen, H. (1999). *Un ensayo sobre la interpretación psicoanalítica.* Buenos Aires, Argentina: Polemos.

Freud, S. (1916-1917). *Introductory Lectures on Psycho-Analysis* (part III). *S. E.,* 16.

——— (1932). *New Introductory Lectures on Psycho-Analysis. S. E.,* 22.

Klein, G. (1976). *Psychoanalytic Theory: An Exploration of Essentials*. New York: Int. Univ. Press.

Lambert, M. J., ed. (2004). Bergin and Garfield's *Handbook of Psychotherapy and Behaviour Change.* New York: Wiley.

Polanyi, M. (1969). *Knowing and Being*. Chicago, IL: Univ. of Chicago Press.

Sandler, J. (1983). Reflections on some relations between psychoanalytic concepts and psychoanalytic practice. *Int. J. Psychoanal.,* 64:35-45.

Staats, H., Biskup, J. & Leichsenring (1999). Changing problems, changing aims: the development of change in psychoanalytic psychotherapy evaluated by PATH, a tool for studying long-term treatments. In *Psychoanalytic Process Research Strategies II,* ed. H. Kächele, E. Mergenthaler & R. Krause. Ulm, Germany: Ulmer Textbooks.

Stern, D. N., Sander, L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Bruschweilerstern, N. & Tronick, E. Z. (1998). Non-interpretive mechanisms in psychoanalytic therapy: the "something more" than interpretation. *Int. J. Psychoanal.,* 79:903-921.

Wallerstein, R. S. (1965). The goals of psychoanalysis—a survey of analytic viewpoints. *J. Amer. Psychoanal. Assn.,* 13:748-770.

---

*Santiago Vázquez 1142*
*11300 Montevideo, Uruguay*

*e-mail: bernardi@chasque.net*

*Psychoanalytic Quarterly, LXXVI, 2007*

# COMMENTS ON THERAPEUTIC ACTION

BY JORGE CANESTRI

I have been asked to write a critical response to the eight essays written especially for this monograph of *The Psychoanalytic Quarterly,* comparing the authors' ideas on therapeutic action, seeking overlaps, syntheses, and incompatibilities. I shall therefore comment on each paper separately.

## ABEND'S "MODERN CONFLICT THEORY"

I shall begin by paraphrasing Sander M. Abend's two preliminary assumptions. He reminds us that in the psychoanalytic literature, the theory of therapeutic action is rarely explained without ambiguity, regardless of the psychoanalytic school being referred to. Consequently, a theory of therapeutic action must be attained by inference from the technical recommendations that every analytic theory promotes in clinical practice.

Personally, I would add another premise: it is reasonable to think that the situation with therapeutic action is not very different from that which characterizes other various concepts that we use in psychoanalysis. The definition of what therapeutic action means to a psychoanalyst will be closely connected to and will depend on the overall theory preferred by that analyst. Every time a concept is examined, the analytic critic must above all ascertain whether it is coherent with the overall theory being taken into consideration. Subsequently, if the analyst wants to test or verify the concept or

---

Jorge Canestri is a Training and Supervising Analyst of the Italian Psychoanalytic Association and the Argentine Psychoanalytic Association. He received the Mary S. Sigourney Award in 2004.

alter it, he or she must bear in mind that the unity of analysis, from an epistemological point of view, is theory, as I have tried to demonstrate recently in regard to the concept of conflict (Canestri 2005).

The reader of this very interesting issue of *The Psychoanalytic Quarterly* can easily find evidence of this: every author included here has taken care to specify the fundamental enunciations of the psychoanalytic theory to which he or she refers, whether it be classical Freudian, Kleinian, self psychological, modern conflict, Lacanian, intersubjectivist, or something else. This gives the reader—and here is one of the merits of this issue—a clear overview of the options, each of which is closely dependent on the selected theory. For example, the role (and meaning) that Kleinian theory assigns to destructive impulses, as well as their *raison d'être*, is very different from that of ego psychology; this is why a very dissimilar therapeutic value has been given to the interpretation of negative transference and of such impulses in these two schools of thought. The same can be said for the meaning that each theory gives to preoedipal and preverbal factors, etc., and therefore to their importance when evaluating what the therapeutic action of psychoanalysis depends upon.

This is not to imply that every psychoanalytic theory, even those that seem to be more distant and divergent from each other, has not undergone "contaminations" deriving from rival theories. The reader need only read the works presented here in order to ascertain, for instance, that self psychology accepts certain concepts relative to the management of affects and the importance of the "use of the object"; that modern conflict theory attributes importance to the vicissitudes of the relationship in the transference-countertransference matrix, etc. But each theory reformulates the imported concept so as to adapt it to the overall theory that is incorporating it and to make it compatible with this set of beliefs. This necessarily implies some transformations of the concept. Some of these concepts end up in harmony with the newer theory; others prove more problematic—even though Freud, and later Sandler, emphasized the importance of the flexibility of concepts in our discipline.

As each analytic theory borrows and adopts concepts from other analytic theories, this phenomenon becomes evident in the clinical practice of the individual analyst, even on superficial examination of his or her clinical work. A huge variety of factors, many of them unconscious, oblige the analyst to use concepts deriving from different theories, and the analyst thus constructs for him- or herself a tailor-made "mixture" for the purpose of confronting the challenges presented by his or her clinical work. This means that many of the factors that come into play in what we call the *therapeutic action* of psychoanalysis can be studied from the viewpoints of the various theories we use, as is well described here by the authors, but also that some of these factors should be studied in the actual clinical practice of various analysts. Probably, research of this kind would reveal elements that we have neglected, but that could prove to be more significant than expected.

Bearing all this in mind, I will begin my comments on the other essays included here.

## SPEZZANO'S "HOME FOR THE MIND"

Charles Spezzano describes the therapeutic action of psychoanalysis as involving "the patient's . . . subjective experience of the mind of the analyst as a certain type of psychic environment " (p. 1563). From a generic point of view, we can have no objection to this principle; on a theoretical level, it can be linked to so-called common-sense psychology, whose presence in the mind of the analyst is highly significant if he or she is to avoid a mechanical application of theory in the formulation and wording of interpretations. Spezzano refers to this when he emphasizes that "the patient cannot . . . become at home in a psychoanalytic theory" (p. 1569). The principle according to which minds act on each other can also be referred to as Davidson's theory, which states that one of the components of an utterance directed to an interlocutor is the belief that the interlocutor has the necessary resources to understand the utterance in the way that it is intended (Davidson 1984).

All of this can give us an understanding of the conception that Spezzano has of the relationship between the mind of the analyst

and his or her preferred theory, and of the necessary personalization that it must undergo in order for the analyst to offer the patient a psychic home. In fact, the author states that "the psychic space that each analyst provides for the patient to inhabit is a theoretically imbued, personal space—recognizably furnished with ideas from the collective knowledge of psychoanalysis, but also showing the idiosyncrasies of the individual analyst" (p. 1570). I fully agree with this statement. For some years, I have directed a research project for the European Psychoanalytic Federation on theoretical issues —a program that is oriented precisely in this direction and toward an examination of the private, implicit theories of the analyst in clinical practice. In this research, we have described a three-component model of theory in which the theory in clinical practice is defined as the sum of the following: public theory-based thinking, plus private theoretical thinking, plus the interaction of private and explicit thinking (that is, the implicit use of public theory) (Canestri 2006). I have said that, from a *generic* point of view, this principle cannot be objected to; however, it needs to be specified within psychoanalytic theory, as it is definitely different from what we think of as common-sense psychology, and is also different from the philosophy of language.

So which are the elements that analytically distinguish Spezzano's "home" from others? The author says that both the analyst and the patient come to the appointment with the analysis to play the analytic game, with "a cast of characters in mind" (p. 1571). However, "the analyst is more able than other people to be helpful in the patient's conflicted effort to change" because he has "*emotional and ideational muscle memory*" (p. 1572, italics in original). These derive from his personal analytic experience and from accumulated knowledge from the psychoanalytic community, which therefore acts as an element of triangulation—a collective awareness that, outside the analytic dyad, counteracts the tendency toward internal closure within a dual relationship. The optimal position of the analyst at work is represented by the delicate equilibrium between closure within the intimacy and peculiarity of the relationship that risks taking the form of an exclusive dyad, and the ex-

aggerated, stereotyped, and prescriptive specification of method that unbalances the situation in the opposite direction.

The author's theoretical structure seems to be concisely expressed in his description of the analytic game as giving "character analysis a new meaning in an object relational dimension of psychoanalysis" (p. 1572). Unlike the other authors in this issue, Spezzano does not offer further specifications about his theory. Perhaps this is due to the inclusion of his later statement that he gives value to clinical material inasmuch as it allows for the recognition of the truth value of interpretations, but, he says, it is useless when attempting to solve disputes about broader concepts, such as the one under discussion here. From this, we assume that, from his point of view, it is not possible to choose from among competing points of view by using clinical work as the determining factor. Spezzano invites us to join Steiner in recognizing that "'it is often impossible to understand exactly what has been happening' [in the consulting room]" (pp. 1577-1578). In this case also, I find it easy to be in agreement. However, we can either choose to accept theoretical relativism, I believe, or else take the direction of augmenting and focusing our research in order to improve our knowledge and descriptions of what takes place in the consulting room.

In speaking with a patient, Spezzano notes, he may allude to "a scene from a novel or film, a joke, a sports metaphor," adding that "sometimes, I find that one of my own such associations is the best way I have to capture . . . [an] understanding [about a patient]" (p. 1570). I think it is useful here to distinguish between what is conceptual and what might be thought of as stylistic. The choice to speak of a novel or to use a sports metaphor is part of the style of the analyst, not a part of his or her conceptual base. It is quite possible that another analyst with the same conceptual base may have a completely different style from this author's. It is equally possible that the style an analyst adopts may vary with different patients; it may even be useful for the analyst to vary it according to the pathology encountered (an example of this can be found in Liberman 1970-1972). From this point of view, I would have liked the author to give more theoretical foundation for his choices of style.

Spezzano privileges the "dreamlike moments of a patient's existence" (p. 1578) and considers them targets for interpretation. He notes that interpretations that highlight these dreamlike moments are, in their turn, the results of the analyst's dream fragments becoming mixed with those of the patient. The author agrees with the philosopher Wittgenstein (1966), who stated that:

> When a dream is interpreted, we might say that it is fitted in a context in which it ends up by being enigmatic. In a certain way, a person who has dreamed goes back to dream his dream . . . . There is an interpretive work that, we might say, still belongs to the dream itself . . . to dream the dream again. [p. 117][1]

Spezzano mentions that he sometimes makes an intervention along the lines of: "'As I listened to you, I found myself thinking . . .' " (p. 1579). I would add that, when the analyst adds a prologue to the interpretation, such as "I was thinking that . . . ," "I believe that . . . ," etc., inevitably, he is making a self-disclosure, and, implicitly, he is taking a supportive action. He may be aware of this and choose to do so, as in this case, or he may be unaware of it.

Spezzano says that "the most distinguishing aspect of what we do is interpreting" because "it is a unique privilege granted to us by patients" (p. 1574), and not because the interpretation has more power to effect change than other factors that come into play in the analytic experience. Many analysts would agree with the statement that interpreting is a privilege granted to us by the patient. In my view, however, there is considerable disagreement about the relative power of interpretation versus that of other factors in accomplishing change. Many of the authors of the essays included here consider that interpretation is the instrument of change par excellence, and I agree with them; but a more detailed discussion of this subject would exceed the limits of this commentary.

I think Spezzano is right to criticize self-disclosure relative to the patient's worry that "there is something wrong with the mind of the analyst" (p. 1580). While the author considers that confes-

[1] Bion (1991) made many similar observations.

sions about the errors, limitations, and misunderstandings of the analyst do not help the patient, he also believes that Steiner's conception of analyst-centered interpretations—in the sense of taking into serious consideration the patient's viewpoint, as well as the meaning of what he or she wants to communicate—is useful and considered so by many schools of psychoanalysis.

Spezzano is not as concerned about self-disclosures involving modalities, styles, and idiosyncrasies of the analyst. It is my belief that there are no self-disclosures without consequences. The use of poems, stories, sports images, etc., can assume many meanings in the analytic relationship, not the least of which is a seductive one. I think a greater articulation between the clinical, technical, and experiential parameters would be helpful to add to Spezzano's essay, including the theoretical parameters on which the author bases his discussion. For the most part, these are implicit or appear only briefly.

## EIZIRIK'S VIEWPOINT

Cláudio Laks Eizirik begins his paper by saying that, even today as in Freud's time, the therapeutic action of psychoanalysis is a "somehow mysterious process" (p. 1463). His essay nevertheless follows an extremely clear route. After starting with Strachey's justly well-known paper, Eizirik presents the ideas elaborated by Klein for a short presentation to the British Psychoanalytical Society in 1949 on the criteria for the termination of an analysis—ideas from which one can also deduce parameters relative to therapeutic action. Among the post-Kleinians, Eizirik highlights the contributions of Joseph, whose work seems more than reasonable to discuss here since psychic change has always been at the center of the English analyst's considerations. Joseph's basic principle for the analyst to follow is to be constantly attentive to discovering where the immediate emotional contact between patient and analyst is manifested, and to keep that contact alive without letting oneself be distracted, in those circumstances, by possible connections with the patient's history or by premature conceptualizations of unconscious fantasy.

This way of working, as Eizirik points out, could lead us to a loss of contact with the immediate emotional reality of the session, and to think of the patient as a "third" reality. The most important task of the analyst in terms of therapeutic action, according to Eizirik, is to give a precise and timely interpretation of what the patient is doing to the analyst or is inducing the analyst to do.

In following his post-Kleinian pathway, Eizirik coherently discusses the considerable influence that the Barangers' theories have had on the transmission of psychoanalysis in Latin America, and he takes into consideration their theories on the *analytic field*. In a relatively early paper, the Barangers hypothesized that the regressive situation of analysis "gives rise to a new gestalt, a bipersonal or basic unconscious fantasy of the couple, different from the fantasies of the patient or of the analyst considered individually. This fantasy underlies the dynamics of the analytic field" (Eizirik, p. 1467). As Eizirik reminds us, this concept is definitely informed by Kleinian ideas, to which the Barangers adhered at the time, but also by ideas deriving from other areas of thought. It is easy to find points of convergence between the concept of *field* and other theoretical proposals that circulated within the psychoanalytic world during the 1960s: a two-person psychology, the interaction between transference and countertransference, and so on.

However, the concept of the field has its own particular specificity, partly due to its roots in Kleinian theory, despite the fact that it deviates from this in significant aspects. The Barangers noted that a link between the patient's resistance and the analyst's counterresistance can give rise to the

> . . . formation of a bulwark in the analytic field, maintained by both patient and analyst . . . . [The Barangers] defined this bulwark as a sort of neo-formation set up around a shared fantasy assembly that implicates important areas of the personal history of both participants, attributing a stereotyped, imaginary role to each. [Eizirik, p. 1468]

Eliminating subsequent bulwarks that become evident during analytic listening—if the analyst takes care to continually ana-

lyze modulations of unconscious fantasy in the field—will be a priority task, ultimately leading to the therapeutic action of the analysis.

Eizirik notes that M. Baranger described analytic listening as a specific form of listening that arises from an implicit scheme of reference—a form of listening that includes the theory to which the analyst refers, together with his or her knowledge of analytic literature, clinical experience, personal analysis, professional identifications, familiarity with theoretical trends, etc. This definition of analytic listening and of the factors that compose it is convergent with present-day preoccupations around psychoanalytic heuristics and the analyst's implicit theories (mentioned previously here). This amounts to being more attentive to what really occurs in clinical practice—to attempts to single out and study the many intervening variables that render the process of the therapeutic action of psychoanalysis a little less mysterious.

Following the same line of thought, the author reminds us of Faimberg's concept of *listening to listening,* resulting from the union of the function of analytic listening with the Freudian concept of *Nachträglichkeit.* The analyst listens to the resignification of his or her interpretation on the part of the patient, and this will help the analyst discover the patient's unconscious identifications in order to facilitate the process of psychic change. This method was used by Eizirik in his analytic work with the interesting clinical case he presents.

The author concludes the construction of his first scheme of reference by mentioning his personal contributions to the issue of analytic neutrality. He considers this concept—rather unpopular in much contemporary psychoanalytic literature, especially among intersubjectivists—to be an important instrument in clinical practice. I agree with him, and I think that most of the criticism against it is based on the distortion of its true nature and on an underestimation of its function. The analyst's neutrality does not describe an expectation of total objectivity, nor does it exclude the fact that the analyst will unconsciously reveal aspects of his or her character and theoretical or ideological positions. Rather, *neutrality* sug-

gests a position of measured distance, a conscious and careful attempt not to pollute, a resolve to help the patient confront him- or herself through someone else—someone, that is, who cannot be a mirror, certainly, nor is the person authorized to be a projector.

Eizirik defines *analytic neutrality* as the behavioral and emotional (I would add *intellectual*) position of the analyst in his or her relationship with the patient, from which the analyst observes various features while maintaining an optimal distance. Among these features, besides the most obvious ones of clinical material and transference-countertransference, Eizirik mentions personal values and psychoanalytic theories, both of which are convergent with the study of the analyst's implicit theories and motivations that I have already mentioned. Similarly, I agree with the author that contesting the epistemological paradigms of logical post-empiricism does not necessarily mean canceling out the criterion of objectivity. As the author says, "in its essence, the search for a possible objectivity is still going forward" (p. 1472).

One major question remains: to what extent is the model of the analytic field compatible with the core of Kleinian ideas? I have doubts about the congruence between the two, but perhaps a consideration of that issue is not essential here. In this paper, I am referring to the theory of the *field* as a clinical theory, at the level of practice and with an instrumental function.

## HINSHELWOOD'S ESSAY

R. D. Hinshelwood accurately illustrates the theoretical foundations of therapeutic action from the viewpoint of Kleinian theory. He also engages in a dialogue with other theoretical schema—mainly, ego psychology and, on some occasions, self psychology. The reader can thus easily perceive the differences and commonalities between the various theoretical viewpoints that populate an increasingly pluralistic and polymorphous field.

Today's theoretical field is submitted to two opposing tensions, as can be seen by reading the essays in this issue. One of the tensions, represented by some of the authors included here, tends

to specify and distinguish as precisely as possible the concepts used and the theoretical sources of reference. The other, of which there are also examples in this issue, is oriented toward a looser relationship with theory and a greater "personalization" of the concepts. Both respond to perceived needs in theoretical formulations as well as in clinical work. On the one hand, it is necessary to make theory as explicit and coherent as possible, so as to facilitate a comparison between competing theories and to allow for an eventual choice to be made on rational bases that can in some way be tested. On the other hand, there is a need to recognize and give expression to the uniqueness of the particular patient and the particular analyst who are united in a process that is always difficult to standardize.

Hinshelwood begins his discourse by making a useful distinction among three different modalities of change. The second, defined as a long-term change that takes place over a period of time and that contains epigenetic elements, is usually overlooked in psychoanalysis. The author rightly emphasizes that the third modality of change—i.e., therapeutic change—must be distinguished from the others because it derives solely from the analysis. Analysts, says Hinshelwood, may be tempted to attribute to themselves changes that would have happened anyway, even without analytic intervention. This is correct, but perhaps it is not always so easy to establish the lines of demarcation. As can be deduced from a reading of this issue, our knowledge about the psychoanalytic factors that produce change is not sufficiently certain for us to state that specific transformation has come about solely thanks to our intervention. The time that passes (*le temps qui coule*, as Michel Serres [1983] says), with its effects that may be epigenetic or not—the Greek *tyche* of the unfortunate encounter—is so interwoven with our lives that it is perhaps presumptuous to suppose that we can dissect with scientific precision that part of change for which we are responsible. However, Hinshelwood points us in the right direction.

The author traces a historical panorama of the theory of change in psychoanalysis, ranging from initial Freudian positions

to those of object relations psychoanalysis. I think that some readers may object to Hinshelwood's criticism of economic theory perceived as an obstacle on the road to a better definition of therapeutic action. But this is one of the theoretical differences that it is not practical to thoroughly discuss in this commentary.

The Kleinian invention of the technique of play, says Hinshelwood, has led to the development of object relations analysis. He notes that, "as in many other branches of science, the invention of a new technique of observation produced new phenomena and a new theory" (p. 1482). I agree with this statement. As I have previously observed:

> The unity of analysis, from an epistemological point of view, is theory. The empirical data with which we work are data of the methodological empirical basis—i.e., they are data that presuppose the use of material or conceptual instruments that in turn derive from a theory. A different theory of the instrument (or the use of a different instrument) has an inevitable effect on the methodological empirical basis, on the method itself, and, consequently, on the theory. [Canestri 2005, p. 301]

During the International Psychoanalytical Association's congress on the psychoanalytic method (2001), there was a lengthy discussion on the uniqueness of the method: one or many? While it may be possible to recognize basic principles that are common to various psychoanalytic theories, as far as methods are concerned—for example, free association, evenly hovering attention, and so on—there is no doubt that the methodological empirical basis for such a principle will be different according to the instruments used. The same reasoning applies to therapeutic action. Hinshelwood is right when he says that the introduction of the technique of play has produced new phenomena and new theory, just as has happened with the introduction of the modern concept of countertransference.

I am, however, less convinced about the analogies that object relations analysts trace between children's play and the analytic relationship of adults, such as is expressed by Hinshelwood in his

phrase "the 'play' an adult engages in with his 'toy,' the analyst" (p. 1482). Analogies of this kind (analyst/mother--patient/child), while they may be understandable from an expositional point of view, can be misleading and can oversimplify the complexity of the analytic experience.

Another important change in the instruments that we use in clinical practice pertains to the concept of transference: the shift from transference as a "usable force"—a position that the author attributes to ego psychology—to its being seen as "a *unique understanding* (and 'insight') about that patient's mind" (p. 1483, italics in original). This leads to Hinshelwood's definition of therapeutic action, which is in line with an emphasis on object relations and the broadening of the transference concept: "From a Kleinian point of view, therapeutic change comes from a deeper understanding and insight into the specific roles and relations exhibited and enacted in the transference" (p. 1483). The transformation concerning the notion of transference, starting with the seminal work of Strachey and continuing through the development of Kleinian theory, represents a significant point of discordance with other psychoanalytic theories—for example, with the view of the transference held by a number of French psychoanalysts.

I think that Hinshelwood suggests a useful distinction between three different ways of strengthening the ego: through better self-understanding (Kleinian), through better organization of defenses (ego psychology), and through specific support to the self-image, which can be achieved by positioning the analyst *on the side of* the patient (as advocated in self psychology). Obviously, these descriptions allow for other specifications, as the author himself admits, but they are sufficient for tracing demarcation lines and for understanding—within the intention shared by various theories of reinforcing the patient's ego—the differences that emerge from a careful conceptual analysis. If, in fact, we examine various suggestions about what the therapeutic action of psychoanalysis is, we find a confluence of different precepts regarding the need to produce a strengthening of the ego; it is more difficult to find concordance on what form this strengthening should take and how it can be

accomplished. Freud (1933) bequeathed to psychoanalysis a famous saying that is open to more than one translation and more than one interpretation: "*Wo Es war, soll Ich werden.*"

"Set free" by analytic theoreticians such as Heimann and Racker, countertransference has become an instrument that is recognized and applied in clinical practice, and not only according to Kleinian theory. Hinshelwood emphasizes that "with safeguards in place, countertransference could be an asset. (Without safeguards, it remains *wild analysis,* as Freud . . . described it" [Hinshelwood, p. 1487, italics in original]), and he proposes a triangulation process: if the analyst's experience of the patient and the patient's material coincide in some way, then we know that the area of commonality represents something of the patient's transferences.

What should we try to avoid when we take this stance? Something about it worried Klein: that use of the countertransference could involve the danger of attributing to the patient the analyst's personal problems. A short step farther leads Hinshelwood to criticize an approach favored by other theoretical orientations (specifically, the intersubjectivist one)—that of satisfying the patient's need to have "an *authentic* response" on the part of the analyst. One could wonder about several aspects of this problem: e.g., which are the theoretical presuppositions that suggest we should satisfy the patient's needs (an idea exactly opposite to the Lacanian standpoint, not to mention the Freudian)? Are these "corrective" experiences really *psychoanalysis?* How can we be certain that the self-disclosure of our feelings does not have defensive, seductive, or other intentions? I completely agree with Hinshelwood's concerns.

I find his explanations about deep interpretations less convincing. I have the impression that he has clearly described the position of ego psychology relative to the care that is needed at the level of interpretation, in order to allow the ego to tolerate the contact with those aspects of the self that the subject feels are highly dangerous. The nature of these deep interpretations is less clear. Hinshelwood refers to Klein's convictions, deriving from clinical work with children, about identifying the difference between ego

psychologists, who are sensitive to the conscious ego of the patient, and the opposite sensibility of Kleinian analysts to the unconscious needs of the patient. But, apart from referring to Klein's work of 1932—which, although innovative, is now considered outdated from a technical standpoint—he does not inform us about changes in the technique of deep interpretation, in the wording of interpretations (nowadays considerably altered since the time of Klein's case descriptions), of the passage from a one-person interpretation to a two-person interpretation, etc. These developments are illustrated in numerous works by Joseph, Spillius, Steiner, and Britton, among others, and it would have been interesting if the author had mentioned these elaborations as well.

Hinshelwood confronts the concept of process and that of containment by creating a link between the techniques that privilege the here and now, as well as the role played by the meeting of the patient with the mind of the analyst. The theme of the meeting with the analyst's mind, as can be seen from Spezzano's paper, for example, is central to today's analysis. Within Kleinian psychoanalysis, Bion and Rosenfeld have provided the major developments in the concept of containment. The mind of the analyst must be able to receive the split-off aspects of the patient and to transform them in his or her own mind. The analytic process thus becomes one of a reparation of the mind, rather than a resolution of conflict, as the author rightly emphasizes. The concept of psychotic parts of the personality (Bion) represents another reason for justifying deep interpretations, which should go beyond the levels affected by repression (i.e., the neurotic levels). This theme, too, is common to a great deal of contemporary psychoanalytic writing (e.g., the works of Green on the *cas limites;* see Green 1997), without this necessarily implying a theoretical orientation that is close to Kleinian theory. I think that Hinshelwood is correct when he characterizes as specific to this conception the fact that the good object introjected in analysis should be a good *understanding* object. This corresponds to the Bionian function of the K link.

In the conclusion of his fascinating paper, Hinshelwood deals with the thorny issue of *destructiveness* and *self-destructiveness*—one

of the themes differentiating Kleinian theory from other psychoanalytic theories. Indeed, the fundamental questions concern the origin of destructiveness and self-destructiveness. Are they primary, derivative, or manifestations of the death drive—or are they instead the consequence of frustration caused by an inadequate environment? As we know, the responses to these questions trace demarcation lines between various analytic theories. The author (I think rightly) agrees with Bion—who was not by chance the one who, through his concept of reverie, restored a significant role to the quality of the external object (primarily the mother)—in saying that, in some cases, Kleinian analysts have misidentified the role of frustration as the source of aggressiveness, while others have minimized the importance of primary destructiveness.

It is natural, therefore, that the mind of the analyst should be employed in the containment of mental states that carry the knowledge of this self-destructiveness, in order to transform it and restore it to the patient. This implies a specific theory of interpretation and of therapeutic action. Hinshelwood hypothesizes that the everyday difficulty in confronting these antilibidinal aspects can induce a strong resistance to, if not a repudiation of, Kleinian theory. But this, too, is an issue that would require further discussion on another occasion.

## AISENSTEIN'S VIEW

Marilia Aisenstein states that the concept of therapeutic action does not belong only to Freudian metapsychology, but rather it underlies the whole work of the creator of psychoanalysis. That the theory of therapeutic action is more implicit than explicit in most psychoanalytic theories is an opinion shared by many analysts (and by some of the other authors in this issue). Aisenstein describes the steps taken by others subsequent to the pathway followed by Freud, singling out different stages or moments and emphasizing the importance of some of them. She focuses specifically on the replacement of psychic working through (*Durcharbeiten*) for the working out of resistances, and the point at which the novelties of

the second drive theory (Freud 1920), together with those of the structural theory, necessitated a considerable readjustment of the theory in general—a step never entirely completed by Freud himself.

Aisenstein understands therapeutic action as a functional aspect of the psychoanalytic process, and its effects, she says, are measured through the improvement of psychic functioning, which moves at the same pace and with a greater capacity to handle conflicts. Agreement on such a broad and general definition is not difficult to reach, but the author rightly reminds us that our understanding and conceptualization of therapeutic action depend strictly on how we conceive the psychic apparatus and the clinical process.

Aisenstein thinks—and I fully agree with her on this point—that in clinical practice, the analyst at work uses both explicit and implicit theories. From Aisenstein's point of view, implicit theories are important for two reasons—again, reasons that I agree with. The first is the broadening of the notion of countertransference and its use, especially among those analysts who may have originally been more reluctant. The second relates to the attempt to understand why, when listening to the clinical material of colleagues whose orientations are very different from our own, we can often acknowledge the fact that they are, in any case, carrying out successful analytic work.

Aisenstein considers, however, that there is a "more obscure part of our theories" that includes aspects relative to transferences and countertransferences, identifications with analysts and teachers, and so on, that escape our control and perhaps our knowledge, and that may surprise us in clinical practice. Her definition of this "obscure" nucleus is "a transferential-countertransferential, theoretical-clinical magma" (p. 1448). These unconscious aspects of our work require analytic methods in order to be identified (see Dreher 2000). They may occasionally appear in supervisory sessions and in discussions of clinical material, and they certainly play a significant role in clinical work. As I mentioned earlier, revealing these implicit theories and this "obscure nucleus" is the

purpose of the research being conducted by the European Psychoanalytic Federation. Implicit theories, which include the "magma" that Aisenstein talks about, may also have significant heuristic power.

Green's quotation about taking into consideration what cannot be remembered, and what, although having the character of a repetition, cannot be recognized as such—a phenomenon that he calls "'*an amnesiac recollection outside the field of conscious and unconscious memories*'" (see Aisenstein's emphasis, p. 1450)—together with the discussion of the interesting case of Vanya, allows Aisenstein to suggest a new definition of analytic work that is close to conceptions in other theories regarding the use of countertransference, the concept of enactment, and other factors. In fact, she redefines the interpretive task of the psychoanalyst as that of carrying out painful processes of binding and unbinding in a field of thought that is *co-generated* with the patient. Thus, the patient's process of working through is assisted by the analyst's preconscious.

I support Aisenstein's choice of devoting some of her attention in this essay to Lacan, in view of the enormous influence he has had on French psychoanalysis—even among analysts who do not follow his theory or his practice. The author accents Lacan's earlier work, and, following Freud, she emphasizes that psychoanalysis must focus first on the psychoanalytic process, not on its therapeutic aspect. The natural consequence, which Aisenstein considers beneficial, is that of not distinguishing what is psychoanalytic from what is psychotherapeutic. There is only one psychoanalytic process and it is therapeutic in itself; the choice of its "frame" is made according to the individual patient's psychic organization.

This section of the paper is too condensed, in my view, and I would like to preface my comments by saying that perhaps there are nuances I have missed. If the author is saying simply that the therapeutic aspect is a consequence of the analytic process (as indeed Freud says), then I agree. If, on the other hand, she intends to say that any treatment conducted by an analyst is in fact *psychoanalysis,* regardless of the "frame" that is used, then I disagree with her. The psychoanalytic experience is many things rolled in to-

gether, but it is also an experiment, even though it is set in motion by two minds at work. As in all experiments, certain conditions must be present. If we vary the regulating parameters, we can do many things, but the nature of what we do will certainly change. Obviously, no one can stop me from organizing a frame that is best suited to the treatment of a particular patient, but this does not authorize me to say that what I do is always and in any case *psychoanalysis,* merely by virtue of the fact that I am a psychoanalyst. This is a controversial topic in our discipline and one that cannot be dismissed in a few words.

The section that Aisenstein has dedicated to interpretation seems particularly useful, especially for those readers who are not very familiar with "French" psychoanalysis—even though this term, which I use for expository convenience, is perhaps inappropriate. There are as many variations in French psychoanalysis as there are within any other geographical area; however, as the author points out, there are some shared aspects as well. Lacan's comment that an interpretation is given not to be understood, but to *make waves* (Aisenstein, p. 1457) suggests some of the peculiarities to be found not so much in the formulation as in the wording of an interpretation, according to this school of thought. Understanding, in this sense, is linked to the secondary process; and the interpretation should be articulated at the level of the first censor, between preconscious and unconscious (see Aisenstein's comments about de M'Uzan's work).

The final section of this essay raises the issue of updating our model of the neuroses and of revising our understanding of the nature of therapeutic action. The author gives examples of how this has been taking place in France, due both to the efforts of the French psychoanalytic community and to the influence of their British counterparts. Quoting Lacan, who considered the cure a byproduct of the analysis, Aisenstein again states that the analytic process is an end in itself. This is not necessarily taken for granted by analysts of other persuasions, however, as will become evident from my discussion of the next essay I will address.

## RENIK'S "INTERSUBJECTIVITY, THERAPEUTIC ACTION, AND TECHNIQUE"

Owen Renik begins his paper by wondering why patients seek psychoanalysis, and he suggests an answer: because "they want to feel more satisfaction and less distress in their lives" (p. 1547). Making this possible represents the therapeutic action of analysis. He also states that a great number of psychoanalytic theories actually describe the same process, with only the vocabulary changing. Renik does not deny the differences between various analytic theories with respect to therapeutic action, however; he believes that what is significant is not really "the *essential nature*" of analysis, but rather "*how to bring about therapeutic action*" (p. 1548, italics in original).

The author appears to adhere to a current of opinion, quite well represented in present-day analysis, that puts into doubt the close relationship between technique and theory, which, by contrast, has usually been taken for granted. Controversies about therapeutic action therefore concern the differences in principles of analytic technique, according to this view. It is not clear to me where these principles of technique derive from, if not from the theories themselves. Does not the technical principle of the interpretation of the transference derive from a theory of transference that varies according to whether the theory considers the transference as a reactivated traumatic past, as present trauma, etc.? We have only to look at some of the essays in this issue to see these distinctions.

The fact that the relationship between theory and technique can be relativized, abandoning linear equations, does not imply that it should be radically eliminated, as it would appear from reading the opening of this paper. Renik surprises me when, after having set out his methodological considerations (to which I will return), he writes that "an analyst's theoretical assumptions are a crucial part of the analyst's subjectivity, and often have a decisive influence upon clinical work" (p. 1552). When he later says that using therapeutic benefit as the outcome criterion in order to assess the validity of his hypotheses and to determine his "moment-

to-moment technical decisions," must we then conclude that the analyst has to eliminate his or her theoretical assumptions in order to take the right technical decisions? Or do we conclude that Renik considers it possible to make technical decisions (implying a reading and understanding of the material) that are exempt from theory? If the latter is the case, then the theory that was thrown out the door would return through the window, and the relationship between theory and technique would be reestablished.

That theory can function as a resistance on the part of the analyst is a recognized fact. The paradox—which is not only a psychoanalytic one—is that knowing the patient through theory is a way of *not* knowing the patient. (I say "not only a psychoanalytic one" because this paradox is valid for any relationship with reality.) But we must recognize that this is also the only way we have of getting to know the patient.

The intersubjectivism that the author refers to is described as an "increased appreciation of the epistemology of the clinical analytic encounter" (p. 1549). I have nothing against this point, even though I feel that giving the name *epistemology* to a careful examination of the analytic encounter is inadequate. I would prefer to define *epistemology* as the study of the conditions of production and of validation of scientific knowledge. From the epistemological point of view, the unit of analysis, as mentioned, is the *theory,* not an encounter.

Let us return to methodological considerations. Renik identifies a problem that in his opinion is decisive: our theories of the analytic process and our technical principles are oriented toward privileging "specifically psychoanalytic goals, formulated separately from therapeutic goals . . . . Specifically psychoanalytic goals necessarily derive from psychoanalytic theories" (p. 1550), and this seems to confer on the analyst an undesirable authority inasmuch as it privileges the voice of the analyst in the dialogue. Lacan gave the name *le sujet supposé savoir* to this imaginary privilege that must nevertheless be analyzed.

Because of the circularity of intersubjectivity in clinical work, it is necessary to find an outcome criterion that is independent

from theory. What is this criterion? It is the patient's experience of therapeutic benefit that should serve to assess the success of the analytic work, according to Renik. He anticipates the reader's objections: the role of compliance in the patient's assessment, that of opposition, and so on. But he nonetheless considers that the patient's judgment will be based on observations external to the analytic relationship and the setting.

It is not clear to me how this line of reasoning can eliminate the expected objections, nor does the author try to clarify this. I cannot see that the "patient's experience of increased satisfaction and decreased distress in life" (p. 1551) is different from the symptomatic relief that Freud considered an insufficient criterion, as Aisenstein recalls in her essay. In this case, the difference between viewpoints—and I randomly mention those of Aisenstein and Hinshelwood, since I have commented on them in the foregoing sections—becomes noticeable. It could be said that these analytic thinkers locate themselves at extreme opposite poles: what is criticized by Renik is privileged by the other two authors. By this, I certainly do not mean that the criterion of the patient's "being well" has no significance, but I believe that it is generic, insufficient, relative, and hard to evaluate. I am even more skeptical about this possibly becoming a dependent variable for arriving at an "approach to validation in psychoanalysis" (p. 1551).

One might wonder whether the circularity mentioned in the work, which forces the search for an outcome criterion, is indeed inevitable and invalidating. I think that a relative objectivity is possible within every system that relies on a theory for reading, interpreting, and organizing a given reality. I will not elaborate further here, but wish only to mention that the subjectivity involved can encompass control parameters within the same system.

To illustrate his ideas, Renik presents the interesting case of Ellen. He believes that if one takes into account the intersubjectivity of the clinical encounter, one will legitimately question the rationality of certain technical principles, such as the anonymity of the analyst and analytic neutrality. But he also emphasizes that only after establishing "the possibility for systematic empirical evalua-

tion of psychoanalytic propositions" (p. 1562) can one begin to assess the impact of self-disclosure, as well as of other issues. The author does not explain what this "systematic empirical evaluation" may consist of, and so I cannot comment on this proposal. As far as self-disclosure is concerned, it is no doubt clear to the reader from my agreement with the critique formulated by Hinshelwood that I strongly disagree with Renik's view as stated here.

After two years of analysis, Ellen "remained in the grip of a kind of hypochondria" (p. 1556), Renik notes. When the analyst asks the patient why she feels that she does not deserve to be happy, Ellen replies that she feels guilty, and in continuing her associations, she elaborates a "theory" about having caused her mother's cancer by literally wishing that her mother would die. Renik—I think rightly—considers the patient's explanations (solicited by her analyst) to be intellectualized and an instance of psychologizing. He finds this an example of the way in which analytic understanding that on other occasions might appear valid was not convincing to him, since it did not bring about symptomatic relief. But I find unreasonable the argument that Ellen's interpretation, like any other interpretation, could be valid on other occasions; an interpretation cannot be separated from the occasion to which it is applied. Second, the interpretation, if wrong, can and must be tested by examining the material that follows it. What is more, in this case, the interpretation to be tested is that of the *patient,* not of the analyst; it is therefore *not* an interpretation, but a defense on Ellen's part, which she employs so as not to enter into contact with the truth—i.e., it is an attack against K.

It is the countertransference ("I began to get annoyed at Ellen," p. 1557) that this time allows Renik to elaborate an alternative interpretation to that of the patient; briefly, he concludes that there was something narcissistic in Ellen's suffering. There is immediately a change in the transference (and, from my viewpoint, this is probably an indication of the fact that the patient's hostile feelings and a negative transference, as well as persecutory feelings, had not been sufficiently analyzed). Renik could then observe that "Ellen had never mentioned anything that she actually regretted" (p. 1558),

and he interprets the fact that her feelings of not deserving to be happy and her expectations of disaster might be linked to an understanding ("which she was reluctant to face," p. 1558) of her having damaged her objects. To herself, Ellen always appears as a victim, but in fact she has also victimized others. Among these others, I would include the analyst who, through his countertransference reaction and the subsequent interpretation, manages to free himself from what could be conceived of as a collusion in, or a concretization of, a certain kind of transference-countertransference situation.

Renik says that, with his interpretation, he brought an opinion of his own into the work, and also made a criticism of Ellen that partially expressed his anger at her. Is this a countertransference enactment? In this case, it could be so; but singling out the fact that Ellen had never felt or acknowledged an authentic regret (in Kleinian terms, that she never actually understood and accepted the damage caused to her objects, nor felt the need to repair them) is not an opinion, but an inference that has its origin in clinical material (evidence). Ellen's reaction of trying to convey reassurance becomes, from this perspective, convincing "proof" of the analyst's hypothesis, and the "confession" of the next session confirms this view. If we wanted to continue in the vein of theorizing a collusion, we might conclude that it consisted in a common effort to deny evidence about a "bad part" of the patient.

I would like to clarify that I do not consider my observations here as anything other than hypotheses on someone else's material—hypotheses that, as always in such situations, cannot be backed up with any verification. I make them only in order to convey that, in this material, I cannot find anything leading me to see a need to apply outcome criteria to an analysis; even less so does the material support the abandonment of anonymity or of analytic neutrality, nor does it support the utilization of any type of self-disclosure. Normal clinical and technical concepts, such as the transference-countertransference relationship, enactment, collusion between analyst and patient, etc., are quite sufficient, in my opinion, to adequately explain what transpired in this case.

## NEWMAN'S ESSAY

Kenneth Newman's paper is one of the most convincing works I have read in the field of self psychology. The author begins by explaining how self psychology sees pathology as "the result of environmental traumata that related to issues involving the establishment of a cohesive self" (p. 1513), a thesis that we know well and that characterizes this school of thought. Naturally, the main hypothesis for explaining therapeutic action from this point of view is that of the mobilization and reactivation of pathological self-object transferences, giving new opportunities to the patient, using the analyst as selfobject, to reactivate derailed developmental processes. Here the author inserts the Winnicottian concept of a "usable object" that can allow for "a new kind of emotional experience" (p. 1515).

There follows a detailed description of self psychology theory and of Kohutian clinical theory, out of which I would like to emphasize the following elements: legitimization of the patient's claims for responsiveness, the conception of resistance (in agreement with Winnicott and Lacan) as an answer "to impingements or empathic failures on the part of the analyst" (p. 1517), different forms of selfobject transferences conceived as expressions of narcissistic needs, the concept of optimal frustration, the optimal use of interpretation in a two-step process (the understanding phase and the explanatory step), the process of disruption and repair within the analytic self-selfobject bond, and the utilization of a self-object to help regulate unmanageable affect states.

The most interesting sections of the paper are those in which the author, on one hand, confronts the criticisms against self psychology, and, on the other, addresses certain aspects that the "classical" Kohutian theory neglected. Among the criticisms, Newman mentions the absence of a theory of conflict and the minimization of the role of drives. He suggests that conflict has not been ignored by the theory, but has been conceived "as emerging from a fear of being retraumatized by unresponsive selfobjects" and "not connected primarily to anxiety about infantile drives" (p.

1523). I would be hesitant to accept such a broad meaning of *conflict,* as I have explained elsewhere (Canestri 2005), but I note that this author's argument is consistent with his overall point of view.

He comments on the common criticism of self psychology that it does not sufficiently accentuate the importance of the notion of bidirectional unconscious communication; but he emphasizes that, even though the interactional component and the countertransference expand the conception of resistance, this does not mean that abandonment of an intrapsychic focus is necessary. I think that proponents of other theoretical currents might agree with this outlook, beginning with those of the Kleinian school, which introduced the concept of countertransference and first claimed its clinical value.

The answer that the author gives to the intersubjectivists' criticism against self psychology is significant. Self psychologists are reprimanded for not using their subjectivity to make their work more authentic. Quoting Lacan, Schwaber, and Teicholz, Newman reminds us that many patients, on the contrary, request an empathic milieu in which the analyst contains his subjectivity; while for others, the subjective expression or the disclosure of the countertransference would prematurely force the patient to focus on the other when he or she is not able to do so. The position of self psychology seems to be more "possibilist" than mine is concerning this point, inasmuch as self psychologists do not exclude that there can be a focus on the mutual impact between patient and analyst, even though they advise a continuous assessment of self-cohesion. On this matter, I refer the reader to my comments on Renik's paper in the foregoing section.

Newman writes: "For Kohut and those who have mainly held to his original ideas about treatment, the pathway leading to therapeutic efficacy seems quite straightforward" (p. 1530). I suspect that this straightforwardness in regard to therapeutic efficacy may be true for most, if not all, psychoanalytic models. Freud was accused of pessimism after having written "Analysis Terminable and Interminable" (1937); over time, we have had to admit that the pathway of the process is not all downhill.

The author underlines various parallels between the model of self psychology and that of Winnicott. I do not know whether the analysts who closely follow Winnicott would agree, but Newman's arguments are cogent in establishing comparisons and convergences. I think that the section dealing with how Kohutian theory has probably underestimated the role that affects have had in environmental trauma and self reorganization is extremely interesting, inasmuch as it provides this theoretical construct with better instruments for understanding the subject's internal world. Therefore, a "faulty management of affects" comes to represent a "second dimension of selfobject failure" (p. 1535). Careful consideration of unintegrated affect states and the treatment of negative affects would allow for a new integration. For this to be possible, the analyst must provide a specific *container* function, including the capacity to hold. Similarities to the thinking of Winnicott and Bion are evident here and are acknowledged by Newman.

States of negative affect also imply a particular way of internalizing selfobjects that results in a new, discrete category of objects: *negative selfobjects.* An incapacity of the caretaker to represent a good enough selfobject, to adequately carry out the functions described by Winnicott (holding) and Bion (container), gives rise to negative selfobject experiences and to the internalization of a negative selfobject. The author concludes that such a situation leads to the fact that "not only may the patient fear the reactivation of early need states, but he may also fear his reactive affects" (p. 1538). This represents a twofold failure.

I should like to emphasize Newman's conceptual effort, consistent not only in its attempts to respond to the criticisms against the theory, but also in integrating it with concepts from other theories by reformulating them in accordance with the author's own personal position. Careful research has been done into possible convergences and overlaps, in itself desirable within a discipline that is not without narcissism in regard to small differences, even those of terminology. By this, I do not mean that complete integration is possible, of course, or even that I agree with some of the convergences suggested by the author, but they are certainly well

discussed here and render the theory of self psychology more consistent with other psychoanalytic theories.

## LANDER'S "MECHANISM OF CURE"

Rómulo Lander places himself among those authors who do not consider "cure" to be an objective of psychoanalysis. Following Bion, he believes that analysis should have as its goal the search for internal truth, helping the patient "to be what he is" (p. 1500) or, alternatively, and following Lacan, helping the patient "not [to] give up the desire" (p. 1500). From a Bionian point of view, Lander reminds us, we must take into account that in order to reach this goal, it is necessary for a *transformation in O* to take place, different from a *transformation in K,* the former being the only one capable of producing a deep transformation accompanied by a "deep emotional experience" (p. 1501). Considering the profound difference between the Lacanian and Bionian points of view, the author does not really explain the congruity between these two theoretical models beyond a few obvious similarities.

Lander continues with a description of the limitations of the cure, warmly supporting variations in the technique designed to respond to differences in the "mental structures" of individual analysands. His nosographic scheme places the neuroses, narcissistic disorders, and borderline cases on one side, and psychotic pathology on the other. In his view, psychotic structures (compensated or stabilized) do not allow for analysis (a "standard cure") to take place, but permit only a "pedagogic activity"—that is, an analysis "directed toward the ego, where the aim is to teach the analysand to survive" (p. 1502).

I have two objections to these statements. The first is the fact that many analysts, from the time of key figures like Rosenfeld, Bion, Segal, Searles, and others, on up to the present day, have found it possible to analyze these pathologies without resorting to variations in technique—unless the use of resources necessary for the analysis to be carried out (such as hospitalization, medications, family therapy) are considered variations of technique. I have treated

psychotic patients and I have supervised more than one analysis of a psychotic, all carried out without variations in technique.

My second objection stems from Lander's phrase *pedagogic activity*. I do not deny that, in certain cases, such an activity may be necessary or the one of choice, even though the results I have been able to observe are not very encouraging in this sense, contrary to Lander's experience; but I do not see how this is related to psychoanalysis. I think that other analysts would speak of a supportive psychotherapy, a psychological reeducation, or the like.

The author also describes a "clinical syndrome of the hole," i.e., a "narcissistic deficiency" (p. 1502). If this "hole" is of considerable magnitude, the transference bond with the analyst becomes so essential for the maintenance of the analysand's psychic integrity that the analysis becomes interminable. In my opinion, the problem is not so much that the analysis would be endless; in a sense and from a certain point of view, many analysts seem convinced that this is true for all analyses. What to me seems harder to accept is that Lander tells us that, although the patient may come to know something about his/her repressed infantile sexuality, the "interior hole" will not be modified in the slightest. I do not believe many of the other authors in this issue, beginning from the one last commented upon, would agree—nor would I.

Lander informs us that the two fundamental mechanisms of the cure are insight and *reliving* (emotional experience). Insight is obtained through interpretation and the analyst's act. "Who really interprets?" the author wonders. The patient does, by creating a new interpretation of his her own, using that of the analyst. I think some parallels can be seen here with Faimberg's *listening to listening,* discussed by Eizirik in his essay (pp. 1475-1476). That the objective of the analytic interpretation is linked to producing "an effect of a signifier" accords with the Lacanian comment mentioned by Aisenstein: "An interpretation is given not to be understood, but to *make waves*" (p. 1457). It is not possible here to engage in a detailed discussion about the fact that an interpretation is destined to produce an "effect of a signifier," nor about there being a statement (*enoncé*) that brings about a latent content correspond-

ing to the enunciation (an *utterance,* in linguistics). All of this derives from the Lacanian *linguisterie;* it is also in harmony with some aspects of Aisenstein's work concerning the role of interpretation in French psychoanalysis.

Lander is right when he says that the *act* is a restricted area. No analyst would be scandalized at having to admit to an instance of acting out, although I think the author does not adequately clarify —even from the viewpoint of Lacanian theory—the difference between an *act, acting out,* and an *enactment.* That acting out has an underlying symbolic theme is an accepted fact; it is also possible that this may produce a favorable effect. But I do not think that this authorizes us to consider it one of the mechanisms of the cure. Considering acting out as a mechanism to produce insight would mean opening the door to many kinds of abuse; Lacan himself gave evidence of this.

Describing the second mechanism, that of reliving, Lander emphasizes that transference interpretations of preverbal, pregenital aspects (for him, Lacan's *imaginary order*) intensify regression and augment the value of the work of transference interpretation, in contrast to "automatic interpretation[s] of transference" (p. 1505). I do not understand what is meant by the latter, considering that the former is a normal transference interpretation for the majority of psychoanalysts.

Lander's statements about the impossibility of transforming one of the basic clinical structures (neuroses, perversions, psychoses) into another, even after analysis, sound apodictic and are not demonstrated. The psychotic structure, the effect of the foreclosure of the Name of the Father, can only acquire a new psychotic symptom (a fourth knot, a *sinthome* in Lacanian language), the author states; it is up to the reader to discover the reason for this.

I consider—as indeed does Lander—that the Lacanian theory of *jouissance* is an interesting contribution to psychoanalysis. I fear that a reader of this paper who is not very familiar with Lacanian thought may find it difficult to understand. At the end of the paragraph, and after having struggled with the peculiarities of Lacanian terminology and formulation that—I imagine for lack of space—the author cannot explain, we know more about what *jouissance*

is not (it is not a symptom; it is not a phantom; it cannot be removed) than what it is. The section about the theory of the phantom is interesting, to the extent that it suggests a clinical treatment of the analysand's sexuality that is considerably different from that of other psychoanalytic orientations.

## SUMMARY AND CONCLUSIONS

I have already discussed the preliminary assumption of Sander M. Abend's comprehensive essay, wherein the author informs us about different versions of modern conflict theory. He finds it important to analyze the historical development of this theoretical "family" of theories, taking into account the various shifts and divisions that have occurred within it—as, indeed, has been the case in all other psychoanalytic theories.

I think it is useful that Abend included the statement made by Abrams in his introduction to a panel on this topic—"Therapeutic action remained linked to a general theory of the mind, to specific theories of pathogenesis, to technique, and to a view of the treatment process" (Abend, p. 1418)—because I believe that the position formulated is valid not only for therapeutic action, but for all psychoanalytic concepts, as I noted at the beginning of this commentary. A concept is part of an overall theory, and it is this, in the final analysis, that must be studied, tested, accepted, or rejected. It is impossible and misleading to analyze a concept outside the context of the theory to which it belongs, as has been shown in the essays presented here.

Abend's analysis of the progressive complexity and articulation of Freudian thought in regard to therapeutic action is detailed and accurate. It is clear that he privileges an interpretation leading directly to the shores of ego psychology; this is the result of his careful historical examination. Thus, Abend values interpretations that promote

> . . . analysis of the transference [because this] helps to overcome resistances, undo repressions, and thus relieve pathogenic fixations . . . . The motives for repression were . . .

> conceptualized [by Freud] as a succession of fears, quite convincing to the child, involving parental disapproval and punishment, which in the course of development became internalized and subsumed under the influence of the moral agency known as the *superego,* itself active in a largely unconscious mode. The *ego* then emerged as the primary locus of therapeutic attention. [p. 1418]

These technical precepts contributed to the development of ego psychology and its concentration on conflict and the management of it that the ego is able to accomplish. Abend relates that, during the Congress of Marienbad in 1936, in spite of some small adjustments, all the participants adhered to the Freudian conception of pathogenesis as "arising as a consequence of the conflict between instinctual wishes and the ego-superego system" (p. 1422). It was through the publication of the books of Anna Freud and Otto Fenichel in the 1930s and '40s that ego psychology evolved toward an analysis of the defenses, Abend notes, resulting in a theory of therapeutic action based on the systematic modification of the ego capacity of the patient to confront and modulate conflict.

The contributions of Hartmann, Kris, and Loewenstein delimited ego psychology with more precision during the 1940s and '50s, but, as Abend says, apart from "small refinements," these authors did not add to the theory of therapeutic action. And so, from the middle of the twentieth century, a well-articulated profile of "shared beliefs" can be traced. From then onward, though, change was already in the air, and theoretical variations began to emerge. As the author rightly points out, these variations began with reconceptualizations about three essential elements: (a) the role of countertransference in the cure; (b) the nature of preoedipal development and its influence; and (c) the complexities of the analytic situation.

Various authors (Loewald, Arlow, Brenner, Gray, and others) —some of whose ideas are very well explained by Abend—have formulated interesting proposals that take into account the above-quoted elements. In my opinion, these divergences have led ego psychology to a situation very similar to that of other psychoanalytic schools. There is not only a theoretical pluralism in the sense

that different theories and models try to account for the structures of the psychic apparatus, of the determining factors in the cure and of the technical problems; there is also a certain pluralism present within the same theory or school. In reality, if one looks carefully at the three essential elements of psychoanalysis outlined above, they are seen to encompass all the major problems that confront psychoanalytic theorizing—and, implicitly, all the possible variations that appear in contemporary psychoanalytic theories. The way in which each theory resolves these three issues can in itself explain the different points of view described in the papers published in this issue.

Abend continues to believe that the traditional emphasis placed by Freud on interpretation of the derivatives of conflict, which facilitates acquisition of insight, is the most important instrument of the therapeutic action of psychoanalysis. Abend says that onto this foundation, we can—and perhaps we must—add other factors: paying careful attention to patients' responses to interpretations, studying the vicissitudes of the analytic relationship in the transference-countertransference matrix (without necessarily subscribing to Kleinian metapsychology), analyzing the presence of unconscious fantasies about treatment, change, and being influenced by others, and so forth. Abend says that a key aspect of the analyst's functioning is his or her "dedication to the usual analytic task of sensing, understanding, and interpreting . . . transference fantasies and their infantile antecedents" (p. 1435).

The reader will see that it is difficult, in any case, to reach a consensus of views in psychoanalysis because, although there may be agreement with many of an author's basic postulates, it subsequently becomes necessary—for example, in this case—to clarify which concept of transference we are working with, what effect we think the analysis can have on hypothetical developmental deficits, through the use of which techniques, and so on.

Abend explains his position clearly and indicates his opposition to alterations in the traditional psychoanalytic stance, with which I thoroughly agree. He considers that there are two central categories to which the therapeutic action of psychoanalysis is to

be attributed: insight, and the analysand's experience of his relationship with the analyst.

In concluding his scholarly paper, Abend accepts that much of the therapeutic action of psychoanalysis and of the technical procedures of the cure is "uncertain and/or in dispute" (p. 1440). Recognition of this, he adds, does not imply skepticism about its efficacy. I am in agreement with these two statements. In modern conflict theory, as in all other psychoanalytic theories, the theory of therapeutic action is concordant with the general assumptions of the theory. All the authors of these essays have written with this concordance in mind, and the overall result is of great interest, reflecting the authors' high level of clinical experience and theoretical mastery.

REFERENCES

Bion, W. R. (1991). *Cogitations*. London: Karnac Books.
Canestri, J. (2005). Some reflections on the use and meaning of conflict in contemporary psychoanalysis. *Psychoanal. Q.,* 74:295-326.
———, ed. (2006). *Psychoanalysis: From Practice to Theory*. West Sussex, U.K.: John Wiley and Sons.
Davidson, D. (1984). *Inquiries into Truth and Interpretation*. Oxford, England: Oxford Univ. Press.
Dreher, A. U. (2000). *Foundations for Conceptual Research in Psychoanalysis*. London: Karnac Books.
Freud, S. (1920). *Beyond the Pleasure Principle. S. E.,* 18.
——— (1933). *New Introductory Lectures on Psycho-Analysis. S. E.,* 22.
——— (1937). Analysis terminable and interminable. *S. E.,* 23.
Green, A. (1997). *Les chaînes d'Éros (Actualité du sexuel)*. Paris: Éditions Odile Jacob.
Liberman, D. (1970-1972). *Linguistica, Interacción Comunicativa y Proceso Psicoanalitico, Vols. 1-3*. Buenos Aires/Galerna, Argentina: Nueva Visión, 1976.
Serres, M. (1983). *Rome: le livre des foundations*. Paris: B. Grasset.
Wittgenstein, L. (1966). *Lectures and Conversations on Aesthetics, Psychology and Religious Belief*. Oxford, England: Basil Blackwell.

*Via Sesto Rufo 23*
*00136 Rome, Italy*

*e-mail: canestri@mclink.it*

*Psychoanalytic Quarterly, LXXVI, 2007*

# WHO NEEDS THEORY OF THERAPEUTIC ACTION?

BY LAWRENCE FRIEDMAN

## IS THERE A QUESTION HERE?

What is the therapeutic action of psychoanalysis? We knew the answer would be complicated, but the question seemed simple enough. The pages in this issue of *The Psychoanalytic Quarterly* show how wrong we were. The answers appear to be addressed to many different questions. Some contributors answer by defining their goals (for instance, happier living). Some answer by describing the general path to those goals (for instance, increased understanding). For some, a theory of action is evident in the contrast between psychopathology and the healed mind, theory of action being the side-by-side pictures of "before and after treatment" (e.g., the overlapping of fantasy and reality versus the ability to distinguish between them —first a weaker ego and then a stronger ego). Many contributors think the best way to answer the question is to endorse useful attitudes or to warn against unuseful ones (e.g., "Adopt an attitude of containment!" "Avoid imposing your own goals!" "Try not to dominate patients!").

One contributor suggests that treatment action is whatever is common to the diverse schools. Some say the question is too difficult to answer, because treatment is too multifarious, complex and subtle, or too variable, or because the forces hide nonverbally in

---

Lawrence Friedman is a Clinical Professor of Psychiatry at Weill Cornell Medical College and a member of the faculty of the New York University Psychoanalytic Institute.

the analyst's countertransference. And some imply that there is no such thing as a theory of therapeutic action, since treatment action is anything and everything that gets results.

From these papers, we learn a great deal about a wide variety of analytic beliefs, all of them, I think, made unusually comprehensible to analysts of other persuasions. Grateful for that, we may yet ask whether they all revolve around a single question, and if so, what answers they suggest.

That is the question we started with. But I think the symposium alerts us to an even more important question: *if* there is a theory of therapeutic action, distinct from theories of goals, technique, and pathology, why is it not always explicitly addressed? More specifically, which theorists address it more directly, and which less, and why? I think the chief value of this symposium is to shed light on that question.

But before addressing that, let's sample some of the answers to be found here.

## SHARED ELEMENTS VIEWED DIFFERENTLY

For an initial overview of common themes and the different ways they are elaborated, it is useful to compare Owen Renik's comments with Rómulo Lander's. Renik writes that the patient and analyst collectively scan and revise old views of reality for the purpose of co-constructing new narratives that change the patient's expectations, assumptions and decision-making. How that is accomplished is regarded by Renik as a question of technique, which, he tells us, is a pragmatic matter of trial and error. We, however, may see more method in Renik's approach than he lets on. Doesn't the passion with which he urges his approach betray an implicit, underlying theory of action? If Renik is right, the analyst achieves results by directing conscious attention to overlooked possibilities that are latent in the patient's own reflections and by suggesting new possibilities that are embodied in the analyst's personal views and attitudes.

Furthermore, Renik's marked preoccupation with the analyst's open-ness, egalitarianism, and answerability to the patient's stated goal, and his studied avoidance of authoritative knowingness, all seem designed (1) to place responsibility and authorship in the patient, and (2) to give the patient an extraordinarily prolonged, unthreatening feedback from another unusually reflective and articulate person's point of view (the analyst's). In short, Renik's implied theory of therapeutic action is that psychoanalysis suggests new angles of attention and new integrations from a new, special person's attitude, presented in a non-intimidating setting of shared responsibility.

Claiming to abjure theory and abstain from speculation, Renik can nevertheless be charged with endorsing three traditional elements of therapeutic action: (1) a context of safety, (2 ) the availability of new perspectives, and (3) something that prods the patient to give up familiar ways. For Renik, the aspect of safety is provided by the open, egalitarian visibility of a benign analyst. New perspectives are discovered in the analyst's undemanding attention and embodied attitudes. And the prod to change lies in the patient's own pursuit of his cure, further encouraged by the analyst's insistence on the patient's responsibility in the treatment.

## THE PROVISION OF SAFETY

To see how differently these three elements can be understood, consider Lander's view. To take the last item first, Lander does not depend on the patient's sense of responsibility to fuel treatment. The patient's self-responsibility is the goal and end product of treatment, not its tool. Indeed, following Lacan, Lander thinks that therapeutic action consists in gently pushing the patient away from his comforting assumption that he can depend on the analyst's authoritative endorsement, gradually forcing him to become his own self-sufficient authority. In this view, analytic action is an incessant process of throwing the patient back on his own responsibility not by Renik's method of soliciting collaboration, but by deliberately frustrating the patient's happy certainty that the analyst "knows" the liberating truth.

With this as the goal, Lander might not be as willing as Renik is to trust that the analyst's personal modesty will disabuse the patient of wishful illusions about the analyst's authority, and so Lander might conceivably provide progressively less suggestive feedback than Renik does, for fear that it will inevitably be taken as the desired, authoritative pronouncement. On Lander's account, psychoanalysis acts by a slow, painful subversion of the patient's search for external validation and definition. The tide of analysis washes the patient out onto a disillusioned shore where, stranded, he can no longer identify himself with his social reflection and is forced to claim the freedom to define himself on his own terms.

While Lander undoubtedly directs the patient's attention through interpretations, the new perspective he counts on arises not so much from the analyst's pointing to something as from the patient's experience of being left progressively on his own. Both Renik and Lander think that de-idealization of the analyst is an important feature of treatment, but Renik sees de-idealization as a means to an end, while Lander sees it as the end (or aim) of the means.

As if that difference isn't dramatic enough, consider the factor of safety in these two theories. Renik reassures patients by being unmysterious and aboveboard. And where does safety fit into Lander's schema? Since he regards self-responsibility as the buried gold rather than the unearthing shovel, he expects patients to find initial safety precisely where Renik warns of danger, namely, in the analyst's authority. Not that analysts have any choice, according to Lander. An analyst can't make the patient see him as an equal simply by acting like one; the patient's wishful imagining is more than a match for the analyst's self-definition. But even if the analyst could make himself seem ordinary, the patient wouldn't tolerate it until late in the treatment. Patients find safety not in equality but in the analyst's supposed authority. The need for external affirmation is precisely the problem that analysis is supposed to cure. In other words, the aim of analysis constitutes the danger the patient is trying to hide from, and therefore safety, in a sense, is antitherapeutic. This paradox requires the analyst to go slowly in forcing self-definition. Approached as an authority, he should disappear only

gradually, like the smile of the Cheshire cat, temporarily holding up an illusory shield of authority against the patient's superego, so that the journey will feel safe enough to begin.

There is here an enormous difference between Renik's theory of action and Lander's: Renik believes that patients very much want to share in revising their personality, while, to begin with, Lander thinks patients very much want not to.

## PROVIDING NEW PERSPECTIVES

What about the other element—the provision of a new perspective? Renik is well aware that patients often distort the analyst's intended meaning, but he believes that frank conversation clears up these misunderstandings. Lander does not share Renik's confidence, but he doesn't feel completely helpless to speak a novel truth in the patient's ear, distorted though it may be by the patient's transference. Despite the patient's spin, the message will retain a core residue of what the analyst intended, and suggest to the patient a possible autonomous goal.

That said, however, one gets the impression from Lander that it is not so much what the analyst does that conveys the new perspective as what he doesn't do, i.e., the authoritative role he gradually relinquishes. Nevertheless, and for all their differences, one thing on which Renik and Lander agree is that therapeutic action uses a reliable wish that patients have to understand themselves—a wish present either at the outset (Renik) or developed in treatment (Lander). They both suppose that therapeutic action at least partly piggybacks on that wish.

I think this exchange illustrates one way in which contemporary discussions of therapeutic action differ from older ones, at least in emphasis. Many of our discussants give greater attention than their predecessors to the twin mysteries of how perspectives interact, and how someone's old meanings morph into something new. Contemporary theorists of action speak explicitly or implicitly about attitudes as well as propositions.

So let's think further about the provision of new perspectives: How does an analyst's perspective mix and mingle with a patient's? The simplest answer is the old one: the analyst points things out and the patient sees what's pointed to. It is hard to find a theory of therapeutic action that doesn't somewhere include such a formula. But we notice in these pages a contemporary inclination to look beyond that simple idea. Most of our contributors do not say that the analyst merely reintroduces—or calls attention to—the patient's own, lost set of buried propositional truths. The analyst pictured here doesn't just amplify the muffled, unconscious declarations that had wanted to be heard but needed an anticipatory echo from the analyst's mouth.

Stated so simply, of course, such a formula was never featured in the whole history of psychoanalysis. Even before defense analysis came on the stage—even before psychoanalysis proper was born—catharsis already amounted to more than simply recovering a truth. And from the time Freud formulated psychoanalysis as we know it, treatment was thought to tangle with attachment and loss and the painful undoing of intricate life solutions. (Freud's shift from meaning replacement to meaning growth, which Marilia Aisenstein refers to in this issue, is not a late development; it is evident already in 1912. See Freud 1912a.) And early theorists of the Hungarian school elaborated the experiential and regrowth aspect of Freudian treatment. (See Balint 1932; Ferenczi and Rank 1925.)

Nevertheless, classical analysts have always been tempted to imagine themselves to be dragging the patient's segregated truths out of their hiding places and making those truths confront each other in open conflict. In this, analysts have felt supported by Freud's second anxiety theory, which seemed to suggest that his earlier picture of patients hanging onto old attachments should now be replaced by a picture of patients needlessly averting their gaze from awareness of harmless impulses. It seemed simple in outline: if patients could be made less anxious, they would willingly recognize and accommodate shunned truths about themselves.

Accordingly, theory of therapeutic action would mainly describe how the analyst pointed out those liberating truths, leaving a

chapter, or perhaps a footnote, to explain how, in the first place, one could induce a realistic view of the very fears that stood in the way of seeing how unnecessary the fears were. It is to the credit of the profession that it never wholly begged the question by assuming that the "safety" of the treatment situation sufficed to bring about such a shift. It was recognized that something more was needed to complete the theory of action, something like chipping an observing fragment off the ego, or like kidnapping, substituting, or reforming the superego, or like intro- and pro-jecting mutually engaged egos. These were ways of acknowledging that a theory of therapeutic action demands a bridge from the analyst's perspective to the patient's perspective—a bridge wider than a shared knowledge of the dictionary definition of the analyst's words. (I think Bion supplied the larger bridge for Kleinian theory, as Loewald did for the Freudian.) There has always been a sense that *attitudes* lurk in the treatment transactions, even before Schafer (1970, 1973a) elaborated the narrative aspect of human self-awareness.

So our contributors are not revolutionary in working into their theories of action an account of how the analyst's perspective intermingles with the patient's. But they do give more thought to the pooling of mentalities, and they tend to regard that as a keystone feature of therapeutic action. The new interest, it is true, is not shared by all our contributors. Instead of pooling mentalities, Renik relies on *ostension*, i.e., the analyst's pointing to elements of the patient's problems and possible solutions (as edited by the patient's own pointing, toward both himself and the analyst). Renik believes that the analyst's pointing will direct the patient's attention as needed, or at least start him looking in the right direction. No mysterious mixing of minds or meanings is needed; it is rather like telling someone that he trips because he forgets to tie his shoes, or as the joke goes, that he can't win the lottery if he keeps failing to buy a ticket.

Renik's awareness of the analyst's subjectivity does not inhibit him from pointing to something objective: what it does is to caution him against believing that he does it authoritatively. In his account, pointing remains a major action of treatment. Renik's is not

a theory of perspectival translations between patient and analyst. (If it were that, he would not have needed to make so much of the analyst's irreducible subjectivity [Renik 1993].)

At first glance, it might seem that Sander M. Abend also counts on ostension as the reorienting force (albeit, with adjunctive assistance), but that view of Abend's message is an optical illusion arising from his use of the mischievous term "insight" to explain treatment action. Pictorially, the term "insight," like the phrase "to analyze something," seems to automatically sweep the analyst's perspective right into the patient's territory without any border-crossing formalities, whereas, in fact, these terms (*insight* and *to analyze something*) actually posit the existence of a secret passport. (Everyone agrees that insight isn't equivalent to the patient saying "yes" to an interpretation, and "analyzing something" never meant just explaining it thoroughly.)

Abend is fully aware that the act of pointing things out is never received by the patient as a simple revelation. Indeed, Abend agrees with Brenner (2006) that what an interpretation does is largely a result of the patient's receptive perspective (which Abend has elsewhere shown can incorporate a whole, hidden theory of cure; see Abend [1979]). I will return to Abend in what follows.

Elaborating on this mixing of analyst and patient perspectives, Cláudio Laks Eizirik cites the Barangers' image of a joint unconscious fantasy wherein both perspectives meet. A similar idea is presented by Charles Spezzano, who depicts a mental world shared by patient and analyst in which the patient's perspective is assimilated but also challenged—the difference from Eizirik being that Spezzano thinks that perspectives are defined by familiar, internalized figures and relationships (in both parties), whereas Eizirik portrays an imagined world that is created somewhat newly from undeveloped, unconscious potentials in each.

To repeat, most of our contributors do not believe that patients change simply because the analyst draws a curtain from concealed items. We get the impression from Eizirik and many modern theorists, just as from earlier ones like Sterba and Strachey, that the analyst's mere act of listening—this new type of outer audience for the

patient's inner talk—is already a mutative factor. The experience of being listened to and understood in a new way might, in itself, alter the meaning of what the patient is communicating. Of course, the nature of that listening is made visible by the analyst's behavior, but the interesting implication is that the analyst's particular comments may be mainly effective not as detached information but *because* they show he is listening in that new way. (See Bakhtin 1981.)

That new hearing may then be elaborated in a collaborative fashion (as Aisenstein says). We are told that an interpretation, so far from simply transmitting just isolated, propositional content, conveys a whole human perspective, and perhaps something even broader. Thus, Eizirik believes he reflects to the patient not just his own attitudes but the patient's attitudes to himself, but altered by being shared with the analyst. And many theorists imply that what's added is not the analyst's personal view, but a view that grows up inside a virtual, new realm created by both parties. For instance, Eizirik suggests that the new perspective arises from a provisional (fantasy) relationship that has been cultivated by both parties.

This theory proposes a mutual *invention* of meaning by the analytic treatment (not something earlier theorists would be comfortable with). It allows that the potential might always have been there, but the actuality is a new creation (which makes us wonder what it means to be potential, and what exactly how it relates to the actual). In a novel environment of mutual therapeutic fantasy, previously unavailable aspects of both parties come to life, and, according to Eizirik, they can be looked at in new and various ways.

In a similar vein, Spezzano tells us that the patient finds a home in the analyst's congenial mind, even though he must share that mind with guests from the analyst's professional theory. The patient trusts the new home because he senses that he is seen familiarly there, yet he is changed by it because it has other rooms than his own. Hearing that suggestion, a conflict theorist or a dissociationist might ask just *who* among the patient's several personae has found a home in the analyst's mind, warning that the patient's lease on the new domicile better be challenged *before* he has made himself too much at home, closing the door on disowned aspects of

himself. It is that worry that makes analysts continually ask, in effect, "How are you trying to be seen by me right now, and instead of how else?"

Be that as it may, Spezzano's general point is that patients allow the analyst to show them new views because they are reassured that those views will be both tentative and not completely alien. Strengthened by his adherence to theory, the analyst provides an accommodating world for the patient to play in, while also demonstrating a more consensual reality. This theory of therapeutic action, to the limited degree that Spezzano thinks one can be formulated, emphasizes a kind of imaginative play-acting in a safe interpersonal space, monitored by a fixed analytic theory.

## INTERNALIZATION OF THE ANALYST?

How extensive is the analyst's attitudinal influence? Once we have said that new items of self-awareness spring from interaction with the analyst's mind, we are obliged to go on and say how *much* of a particular analyst's mind is incorporated along with targeted features of the patient. When the analyst introduces something to a patient, how narrowly defined can it be? Does an intervention display one specific new possibility for the patient to contemplate, or does the analyst implant his own broad vision as context? Does the patient carry away his own, expanded self, or is he made into something else because the analyst saw him that new way? Does the terminated patient continue to see himself through his analyst's eyes? Does the patient, perhaps, take away a whole, borrowed view of the universe?

Some of our contributors take up this challenge and try to specify how much of the analyst is carried away by the patient. Spezzano's analyst seems to accept a lasting mixture of internal worlds, but tries to limit his intrusion and avoid a *folie à deux* by respecting the restraints encoded in his theory. Eizirik thinks of the mixture as a temporary joint fantasy constructed for examination during the treatment.

In contrast, Kenneth Newman believes the analyst is incorporated as a lasting feature of the patient's mind, albeit in increasingly rarefied form, i.e., less and less in a personified scene and more as an implicit background. Like many of the others, Newman tells us that the constructed relationship is no mere transient companionship. True, it first serves a facilitating role, providing the necessary safety for emerging wishes that had been protectively aborted. (This reminds us of the importance of hope in many theories of action, as evidenced in French [1958], Ferenczi and Rank [1925], Balint [1932], and Winnicott [1955], among others, not to mention the classic statement by Jerome Frank [1961].) But the analytic relationship is not just a source of security. In the course of treatment, the patient will have discovered a whole new world of experience while living in an analyst-populated fantasy. Bathed in that light, genuine aspects of the patient's self are born that had not only been unavailable, but also were previously merely potential; they would never have been actualized except in conjunction with an empathic partner. In some form, the memory of the analyst-partner will forever attend those new facets of the self even as they become automatized affect regulators. The personal quality of the atmosphere of safety that facilitated development will continue to characterize the lasting security that results. As Newman sees it, post-termination safety is partly the implicit memory of the analytic relationship.

Newman agrees with Lander that authoritative protection is the safety that patients crave, but he emphatically denies that the analyst's aim is to strip it away. Indeed, he thinks that what Lander regards as a pathological self-estrangement in search of another person's approval is nothing less than the necessary and natural condition of the human being. Therefore, Newman is happy to see the analyst's aura cling to the new perspective he introduces, albeit in progressively more ethereal forms, sometimes as a kind of template for modulating intense and disruptive feelings.

At the opposite extreme, Renik (as I read him) denies that patients who learn about their pointed-out problems and newly suggested solutions are thereby buying into the analyst's values.

They are simply learning something about the world and about themselves, and perhaps some previously unseen ways of looking at things. They might well retain a grateful—even cheerful—memory of the analyst's company, but that's not part of the cure. (In fact, an acknowledgment of the "irreducible subjectivity" [Renik 1993] of the analyst helps patients discover something objective about how to get what they want and need.) There Renik joins Abend, who grants that long acquaintance inevitably leaves its mark, but doubts that the memory of it is part of therapeutic action.

## MANUFACTURING NEW MEANING

An analyst can easily think of himself as simply directing conscious attention to important aspects and connections that the patient has already identified semiconsciously, preconsciously, or unconsciously. But how about analysts who think that their own imagination *mixes* with the patient's? How do they suppose the patient profits from joining his mental world to the world of the analyst?

It's all very well to say that patients explore themselves in the relationship or in the analyst's mind or in a joint fantasy, or that they receive transformative reactions from the analyst, but unless we can say exactly how that is different from every human interaction, we haven't ventured a theory of therapeutic action. It's no easy task. Out beyond explicit interpretation, the landscape invites metaphorical rather than literal description. And that is a problem because metaphors are more useful to the practitioner than to the theorist. ("Containing" is a case in point.) What exactly is it that analysts do, or allow to happen, that yields a new type of outcome?

In answer, we find two suggestions in this symposium: One is that patients get caught up in the analyst's fostering sort of imagination, which facilitates vertical "maturation" of the patient's raw meanings into more thinkable form (much as stem cells become organs). The other answer is that the analyst sparks a kind of *play* that automatically elaborates new meaning within the patient (and perhaps within the analyst). I'll take up each of these in turn.

## MEANING EXPANSION BY MATURATION OR REFINEMENT

One obvious possibility is that patients find more articulated meaning when they bump up against the analyst's words and concepts. In that encounter, they develop specifiable, delimited, sayable meaning of the sort that can be integrated with other of their meanings and wishes. That is how Loewald (1960) thought interpretations work. He believed that patients learn to refine inchoate urges by imitating the analyst's persistent meaning-making. It is a formula that is now identified with Fonagy et al. (2002). And we can see variations of it among our discussants.

Drawing on Bion, R. D. Hinshelwood says that analysts model a way of making meaning that avoids distortions of love and hate, and shows the usable (K), "intelligible" meaning of what patients have been too scared to experience. Like Spezzano and Renik (but unlike Lander), Hinshelwood thinks that analytic process partly rides on a natural effort of patients to understand themselves, an effort they had fearfully aborted in early life. Patients become able to explore what they are afraid of when they see it as their analyst imagines it. That, too, frightens patients, but it is safe enough to allow them to give their analyst clues to their fears.

Hinshelwood sees patients "toying" with the analyst to illustrate their problems as children use toys in play therapy—a wonderful image that also resonates with Spezzano's. My sense of Hinshelwood's theory of action is this: the patient recognizes purpose and sense in disowned wishes and feelings as they are reframed in thought and action by an analyst who does not obtrude his own personality, but calmly appreciates the anxieties that interfere with self-recognition. The analyst's example encourages the patient to adopt a similar way to make sense of wishes and impulses.

Now, that formula can be found in almost any interpretive theory of action, and it does not do justice to the complexity of Hinshelwood's theory. For one thing, he also acknowledges a darker truth—namely, that patients actively combat the supposedly helpful

understanding. With that Bionian emphasis on countercurrents, Hinshelwood spotlights "resistance" more explicitly than many analysts of his persuasion who think of themselves as mother birds taking up raw impulse and feeding it back, "digested," to their patient.

But the "digestive" theory is prominent in many of our essays. Both Lander and Hinshelwood cite Bion's idea that patients infuse the analyst with undifferentiated intentions in order to have them returned in meaningful packages. In some ways, Newman's description is similar to Bion's, in that the analyst's reaction is seen to crown truncated desires with growth-related meaning. Indeed, Newman (like Bion, and like Kohut 1984) describes the analyst as simultaneously sharing the patient's perspective and putting a sensible spin on it. Aisenstein believes that the analyst adds definition to what is undifferentiated. (As in all classical theories, this belief stands in dialectical tension with her effort to disappear as an authority.) One frequent theme we see is that analysis makes meaning out of what previously had less meaning, something that initially is a bare "force," as Hinshelwood might say. Others describe this process as turning energy or passion into thought, feeling and quality. It is quite a different picture from the older plan of identifying already structured conflicts.

Buried in these discussions, I believe, is an implicit reference to the analyst's special combination of detachment and mobility—a combination that makes "mixing" with him a different experience from sharing with others. In one way or another, our theorists require the analyst to *separate* himself from the experience foisted on him by the patient and to remain always open for other arrangements. Spezzano refers to the analyst's world as half shared with the patient and half pledged to theory. Hinshelwood's cycles of introjection and projection may sound like mutual incorporations, but I believe the image refers to the paradoxical obligation of the analyst to function as a malleable audience (where the patient can play with his own projections) while yet maintaining a stubborn streak of independence (so that the patient can see himself reflected differently than had been his lot).

Obviously, both experiences require that (first) the analyst and (then) the patient take some distance from his natural perception and response. The original recipe of psychoanalysis, from the time of Freud's earliest formulations (1912a, 1912b), was to make patients both feel intensely and take distance from the immediacy of that feeling. We might even say that a theory of therapeutic action is simply an account of the forces that arrange that particular dissociation.

## MEANING EXPANSION THROUGH PLAY

An original Freudian image and a subsequent analytic commonplace portrays treatment as a playful or exploratory setting where specific conflicts and potentials tumble into visibility—a stage where disowned aspects of the patient can tentatively audition again. For example, Spezzano thinks that the patient can risk unaccustomed ways of relating to people if it's done in a playful mode. Aisenstein sees analytic interaction as an open field for creativity and an enticing demonstration of how the mind can be used for its own enjoyment.

## BUT CAN WE EVER REALLY SAY WHAT IT'S ALL ABOUT?

I turn now to our doubters. They are not absolutely agnostic on theory of action. They have many particular ideas to contribute. Abend is willing to acknowledge a great many unspecifiable actions of treatment that emanate from just the prolonged, benign relationship. He implies that patients often heal themselves (or, conversely, negate the effect of treatment) by their own theory of therapeutic action. Abend also agrees that an atmosphere of safety is one of the special ingredients in the action. And we know that he believes another ingredient is the avoidance of a fixed relationship, since he cautions against acting as a particular figure for the patient. But as to a special mode of analytic action he is as wary of speculation as Renik.

Both Abend and Renik regard technique as the fundamental reality, the rest being either a matter of trial and error (in Renik's case) or a mere redescription of technique in terms of one's favored theory (Abend's belief). That doesn't prevent Abend from being skeptical about factors mentioned by others (as I am sure Renik is as well). For instance, Abend is not as convinced as Aisenstein is about the effectiveness of the analyst as a model, or the general process of elaborating meaningfulness, or the helpfulness of the patient's joy in thinking. He relies more on specific insights, which, being a term of art, does not compromise his agnosticism about theory.

Regarding new perspectives, Abend thinks the analyst is required to explicitly direct the patient's attention within the setting of a structured relationship. According to him, analysis achieves its effect by progressively directing the patient's attention to unperceived elements of crucial problems (conflicts). Attention is directed by perspicacious pointing (interpretation). But according to Abend, how that helps cannot be said; all we can say is *that* it helps.

## IS THERE A TREND HERE?

Can we detect a current trend in these discussions? I think so. Whereas earlier authors saw the analyst as decoding contents and introducing parts of the mind to each other, the contributors to this issue (Abend and Renik excepted) tend to explain therapeutic action more as meaning formation and meaning expansion. (Aisenstein is particularly clear on this point.) This emphasis on process has two merits: It says right off how the analyst's impact alters structures. And it confronts the gap between the analyst's output and the patient's input. In other words, a process theory at least tries to say what event corresponds to the verb ("to change something") instead of escaping into the more easily described noun ("this is the change"). Of course, that is only what one would expect of a process theory.

But process theories of meaning-making are plagued by the very generality that makes them useful. With them, we enter the por-

tal of academic psychology (which studies general meaning formation), and we hear the door slam behind us on our *specialized* psychology—the psychology that was tailored expressly to the *particular* kind of interests that control the *particular* kind of meanings that analysts *particularly* want to change. Abend quietly reminds analysts that they have at least some expert knowledge about the passions they deal with, but only amateur imaginings about the cognitive psychology of meaning in general. And so he stops short of that portal.

## MIND IS A UNITY; MIND IS A NEXUS

Like all practical procedures, psychoanalytic treatment must take its place in the natural order of things. That is, it must capitalize on universal mental processes, encouraging some and restraining others. In one sense, a fully elaborated theory of therapeutic action would be a recipe for what is to be up-regulated and what down-regulated in the ordinary, chugging engine of mind. In other words, a proper theory of action says which ordinary variables of the patient's ordinary reaction are accentuated by the procedure at the expense of which other variables.

But we don't have the luxury of such a selection even in our strategic planning, let alone in the clinical moment. What we have before us in treatment is a whole individual, and the item of the patient's mind that we think we're working on is at best more like a heavy line in our sketch of him than a bulging piece of the psychic organism that has herniated into clear view. No sooner does a theory of therapeutic action do its duty by telling us which natural operations we should encourage at the expense of which others, than it is invalidated by the dizzying push and pull among all of them together.

I have already referred to the paradox of safety. It is a case in point: find a sense of safety and draw it out, we are told; that is our universally acknowledged baseline for therapeutic action. But we have noted that whatever enhances safety in one sense threatens it in another. Lander recognizes that the patient is intimidated by the imagination of the authoritative analyst whom he also desires. (That

is Gray's [2005] point, as well.) Lander recommends that analysts provide safety by temporarily granting the desired benediction, but his main point is that the greatest safety would be (and hopefully will be) the patient's *indifference* to benedictions, and that is something he can learn only from an analyst brave enough to sidestep the expected image of an approving authority.

We see a similar complexity among the other contributions in this monograph. The fact that one kind of safety inhibits another lies at the heart of psychoanalytic treatment. It is, in form, the paradigm of Freud's mature theory of neurosis. It probably explains our contributors' frequent concern about authority, a feature that has startlingly mixed impact on patients. Such interrelations and tensions between contradictory effects of the analyst's action partly explains why it is hard to frame a theory of therapeutic action in naturalistic terms.

The problem of safety is just one example—and probably the simplest we can find—among the infinitely complex web of consequences affected by whatever we do and whatever we focus on. For instance, several commentators believe that treatment is supported by a universal wish to understand oneself. Obviously, that factor—the wish to know oneself—is not a simple force that moves in one direction. (Freud certainly thought it wasn't. One aspect of his revolution was the declaration that there is a universal wish to misunderstand oneself.) All in all, and even after we've given the dissociationists their due, the fact remains that a person isn't a crowd of separately acting selves to be conducted like instruments in an orchestra—a little louder in the strings, a little softer in the brass. On the contrary, a person makes a concerted bid on the analyst. An analyst's encouragement of a natural process going on in the background is a snub to the one in the foreground.

But if we can't pull a single thread of natural growth out of the tangled fabric of mind—if there's no strand that we can endorse for itself alone—what does it mean to say that treatment endorses a natural process? Simply that we meet the patient's growth needs? That's a formula not worth formulating.

## MINDS DO THEIR OWN THING

A corollary of the oneness of mind is that mental contents get their significance from their relationship to other contents of the same mind; in other words, therapeutic action is the product of the patient's contexts of meaning, not the analyst's. The fact that patients make their own meanings is increasingly acknowledged, and virtually all our contributors refer to this in one fashion or another. (Glover [1955] called our attention to it. Lander is eloquent on this score.)

When we speak of "the therapeutic action of psychoanalysis," we are talking about the *patient's* process—his handling of the analyst's action. "Theory of therapeutic action" should be an account of how we corral the patient's own, definitive efforts. Since the patient has the upper hand in the exquisitely private theater of his mind, a theory of therapeutic action always seems to fall just a little short of showing our control. Yet we must show control in one way or another, or we have no reason to believe that psychoanalysis *has* a particular therapeutic action. Just because analysts perform a characteristic ritual over and over again doesn't mean that various patients make even roughly similar use of the service, or that the benefit has anything to do with what we think we're doing. (See Abend's [1979] comments on how patients may fit treatment into their own theory of cure.)

The fashionable term *co-creation* names the problem, not the solution. It is today's replacement for the old projectile theory of interpretation, according to which analysts blast a well-crafted proposition directly into the patient's head. The projectile theory displayed not so much arrogance as naiveté about communication. And for all its greater modesty, *co-creating*, like *the therapeutic alliance* and other comradely notions, is just another image of a control that we wish we had. (See Schlesinger 2003.) Co-creation really says only that whatever we do ends up however it ends up, and that we probably had something to do with the result.

To balance the awareness that patients cannibalize interpretations for their own purposes, working psychoanalysts, whatever their theories, have always had to assume that somewhere, somehow, patients want to know about themselves objectively, and that a natural process of self-inquiry will ultimately seek and welcome the analyst's outsider perspective, provided that the patient isn't hobbled by fear. It should be noted, however, that this common, working stance need not determine a theory of therapeutic action. Freud did not assume that the patient's wish for knowledge was a powerful treatment factor (though it could afford satisfaction once acquired). Nor did many who followed him. Nunberg (1948) did not. Sterba (1934) did not. Klein (1975) did not. Brenner (2006) does not. But recent theorists have frequently invoked the wish to know about oneself as a natural process that treatment can make use of, even while other motives get in the way; examples are to be found in Loewald (1960), Bion (see O'Shaughnessy 1981), and Myerson (1981).

And in our group, we have Lander's patient who is in love with knowledge, and Hinshelwood's patient who wants to playfully understand. Aisenstein aims to encourage pleasure in thinking. (One supposes that Bion introduced this theme to give Kleinians a rationale for their confidence in the restorative effect of interpretation.)

## TREATMENT IS SUPPOSED TO CHANGE THINGS

But that's not the end of it: a theory of therapeutic action must do more than show how treatment fits into the natural process of mind; it must show how it (partly) subverts that natural process—show how it subverts the patient's usual way of assimilating personal interactions. (For that reason, psychoanalysis traditionally encourages regression, destabilization, defense analysis, etc.)

Showing how treatment subverts a natural process is tantamount to saying why treatment is difficult. We may never be able to say how treatment works, but if there is any possibility of making a

decent pass at an answer, it will probably be by generalizing our wisdom about clinical difficulty.

Perhaps we should say, then, that any generalizable theory of therapeutic action must be convertible to a generalized theory of resistance.

## HOW CAN WE VIEW RESISTANCE AS BOTH NATURAL AND WILLFUL?

A theory of therapeutic action without a conspicuous account of resistance is like an aeronautic theory that simply lists mechanical parts and never gets around to saying how the airplane overcomes gravity. It was, after all, man's wish to pit his will against the will of gravity that started him on a theory of the therapeutic action of aeronautics. If we hadn't begun with wanting to make the ponderous vehicle stop hugging the ground, we wouldn't have troubled ourselves with aerodynamic theory. In like manner, a theory of therapeutic action is just the inverse image of the theory of resistance.

To picture a whole mind as working against itself, and thus partly working against the analyst, we are required to think of that mind both as having diverse intentions within itself, and as having an overall thrust toward the analyst. We imagine the patient to have an overall (conscious and unconscious) intention to disguise his purposes, to deceive himself and the analyst, in order to further and protect a variety of wishful aims. Even while agreeing with Freud that impulses "want" to reveal themselves, we know that the whole patient we encounter is willful and tendentious. Schafer (1973a) has described that beautifully. (Paradoxically, it's Schafer [1973b] who has most strongly argued against the notion of resistance. But that is more a matter of the word's etymology than the concept, since Schafer deals extensively with defenses that are characteristically arrayed against the aims of treatment—for instance, evasion of responsibility by reification, etc.) It is the patient's will against the analyst's. Freud grasped this from the beginning.

The practicing analyst's questions are: How is the patient fooling himself? How is he trying to deceive me? What doesn't he want me to know? What is this appearance instead of? That is not to say that patients have no natural wish to understand themselves, as many of our contributors believe. Certainly, the analyst has an obligation to look for allies wherever he can find them, and to recruit any brave inclination the patient may have to use the analyst's challenging interventions profitably. And a patient's desire to come to terms with himself or his loved ones may surely be one such. But if the analyst—instead of concentrating on the difficulty of accomplishing his mission—builds his theory of action upon the patient's enthusiasm for learning, it will not be a theory of specifically psychoanalytic action.

In the heat of battle, the sense of the patient's personal, answering effort (the original inspiration for the term *resistance*) signals that we are dealing with something that can be identified. Difficulty (resistance) becomes an orienting beacon for the practitioner. We know there's something there when it pushes back and reveals its specific liveliness.

Now consider a therapist (like Abend) who mainly wants evidence that he is tackling something specific, and is thus intent on interfering with—rather than facilitating—the patient's accustomed meaning making. Such a therapist wants to feel the particular intention—the wish—that he is destabilizing. (I don't need to add that by referring to "a wish," I am abbreviating constellations of wishes known as wish/defense compromise formations, etc.) How will such a therapist respond to a question about therapeutic action? Uncomfortably, I should think. He can feel the question drawing his eyes away from the patient's intentionality. If he allowed himself to think about natural processes while attending to his patient, he might end up cheering the process along. And then, tapping out the gentle rhythm of his patient's natural process, he might gradually be lulled into "synchrony," blinded to concealment and disguise, credulous, manipulated, and utterly lost as a psychoanalyst. It's not worth it, he thinks.

So when you ask such an analyst about therapeutic action, he will not rhapsodize about the grand, natural flow of meaning-mak-

ing. Instead, he will point to the particular earthy meanings he has fished out of the flow and wants to destabilize. *His* theory of therapeutic action will be a story of the fantasies he exposes or the compromise formations he dissects. And we will not be surprised if he replies to questions about therapeutic action by citing technical maxims. He knows, of course, that it is all part of a causal process; he knows the patient is always behaving naturally and doing what he must; he knows that his own actions blend somehow into the patient's psychic causality, etc. But he also knows that his analytic stance, hard to maintain under the best of circumstances, is likely to be corroded by any natural science aura of automaticity that seems to validate the patient's innocence.

The practicing analyst has an opposite worry as well. Since his only instruments are his attitudes and specialized meanings, he must protect those attitudes and meanings from the sort of dramatic idealization of himself that grand theories tend to provoke. If he is to preserve his role as practitioner, he does not have the same liberty to imagine his activity as variously as a laboratory scientist might, except as he tries on his patient's views of him. Such single vision might seem unbecoming of a thinker, but consider how, in ordinary life, self-consciousness commonly interferes with sincerity. If you were self-conscious about your discourse strategies in everyday life you would be unfit for society. The practicing analyst must take care that a scientific *recognition* of efficient causality doesn't *subvert* his causally efficient force (which partly depends on his seeing things as a matter of intention and choice rather than efficient causality).

For example, once an analyst comes to think of himself as tweaking changes in a habit machine, his effective meanings will turn into a manipulator's meanings, and those actions are different from similar actions by an analyst who is imagining himself to be not training a habit, but struggling with a patient's purposeful concealment. (See Freud's [1912b] double injunction to regard transference as natural and as resistance.) An analyst who is comfortable with a theory of therapeutic action and who believes he is "working" a natural process, will in turn produce different meanings in the

patient—will actually input different causes to that supposedly automatic process—than the one who, agnostic about theory of action, steadfastly feels himself to be struggling with a resisting person. We may not know what the difference is, but ordinary experience assures us that there will be a difference between the impact of two such analysts.

My guess is that Abend senses these twin hazards of a theory of therapeutic action, and believes that a theory of action in the analyst's mind makes him either too passive (as a companion) or too manipulative (as a pseudoparent). Abend, I think, is not about to trade a therapeutic power for a neat theory.

## CONCLUSION

Well, then, who loves theory of therapeutic action and who doesn't? I offer the following oversimplified answer:

(1) Analysts who wish to focus on particular, personalized resistances will tend to avoid theory of therapeutic action. (A theory of resistance will make an analyst suspicious of anything that passes itself off as a natural process, since seeing things "naturally" invites analysts to accept the patient as he is.)

(2) Conversely, analysts who readily focus on therapeutic action will tend to avoid the concept of individualized, personal resistances. (Any cited resistances will be very general, such as the demand for direction [Lander], or the general fear of novelty.) These are the analysts who want endorse patients' efforts as part of natural growth; theory of therapeutic action allows them to do that.

(3) Analysts who wish to avoid both the concept of resistance and theoretical pretentiousness will declare the question irrelevant (Renik), saying, "Come, let us cultivate our garden."

## "INTERPRETATION" VERSUS "THE RELATIONSHIP"

Furthermore, I suggest that analysts who focus on resistance, and who therefore avoid theory of action with its non-resisting natural process, will instead emphasize the neutral, propositional nature of their interventions because they don't trust natural process to construe their attitudes in a therapeutic way. These skeptical analysts try to strain out of their interventions as much of the ordinary social framing and pushing as they can, and trim their interventions down to objective pointing. Their focus on interpretations and insight should not be understood solely as a concern for objectivity. They hope to limit their *judgmental* force through pure propositional meaning, coning down on this or that fact, rather than leaking a vague, interpersonal innuendo that spreads out to bless or curse the patient as "that sort of person."

At the same time, since they are thinking only of propositional truths, it will be even harder for these analysts to say how and why the analytic context alters the patient's stereotyped processing, and therefore harder to say why they are effective. Freud's principle that interpretations are accepted out of love for the analyst doesn't really tell us what *acceptance* means. One supposes it involves *looking* at something with a particular *perspective.* But if that is what it means, it leads into the study of the *transformation* of meaning, and there we are beyond the domain of pure, propositional truths, without a chance of recapturing a narrow and specific focus.

The result is Abend's (and Brenner's) agnosticism concerning theory of therapeutic action. Ironically, these "single-method" analysts come to the same conclusion on the unfeasibility of a general theory of therapeutic action as the "variably pragmatic" Renik does.

On the other side of the fence from them, analysts who think of themselves primarily as falling in with a natural process are at liberty to talk more of the *relationship,* since, although everything that happens between people is both a relationship and a message (see Burke 1935), the term *relationship,* when used in analytic de-

bates, tends to denote what is natural and concordant in the situation. (Analysts who say that it is the relationship that counts are not usually thinking of the orneriness of the relationship.)

Now, I hasten to add that my comments on our contributors necessarily caricatures their work and ignores their meticulous inventory of active ingredients in treatment. (Indeed, that profusion is a feature of newer theories of action.) I have made our authors seem more one-sided than any of them are. My categories are heuristic, and do not describe any actual theorist. I have tried to pick up tendencies. In actuality, not one of our contributors fails to touch base with all the considerations of both practice and theory. No psychoanalyst entirely avoids the designation of an obstacle he must overcome, and none avoids the at least tacit assumption that he is joining some natural wish of his patient to improve the natural process of thinking. But there is a wide chasm between those who see the perfection of meaning-making as the fulcrum of treatment (including the Boston Change Group [Stern et al. 1998] and Peter Fonagy [Fonagy et al. 2002]), and others, who think that what distinguishes psychoanalytic treatment from other talking therapies is its unnatural deconstruction of desire.

I submit that the need to describe treatment as both something that is carried forward on natural inclinations, and yet something that interferes with the patient's intentional strategy is what make theory of therapeutic action a supremely difficult study. Transference love was the paradigm of this problem; it established the hybrid structure of Freud's theory of the mind as causal and intentional—force and meaning in Ricoeur's (1970) formula.

These disparate aspects of treatment action—treatment as homologous with normal physiology of mind and treatment as opposed to the patient's ordinary motivation—reflect the psychoanalyst's two ways of regarding the mind. The mind can be thought of in terms of efficient cause, or it can be thought of in terms of (Aristotelian) final cause, that is, as either automatic sequences or intentional sequences. And most peculiarly, it can be thought of as both together, which is how it's considered in Freud's theory and in analytic practice. Linking both views together in a theoretical project is not easy, or even, in principle, entirely possible. Freud did it

about as well as it can be done. Most people today can't be bothered with the meticulousness it requires and they are satisfied with an assortment of heuristic metaphors and inspiring images.

But we persist in hacking away at the bit of theory that concerns therapeutic action, and it leaves us dizzy from the double vision I refer to. Like it or not, practitioners have no choice but to accept both images at once: they must see the patient as an organism that can only be helped to do its own thing, and they must see the patient as a slippery customer who will do better if not taken at face value. Wrestling with that problem in their daily practice, analysts who turn to the theory of that practice are thus confronted by the very challenge they hoped to be done with when they gave up on theory of the mind.

Perhaps a complete theory of therapeutic action would take the form of a figure-ground puzzle, with analysts alternately glimpsed as habit-trainers aiding natural processes and as troublesome interlocutors interfering with their partners' intentions. It seems that theory needs both pictures, but whether practice also benefits from the combination is another matter altogether.

## REFERENCES


Abend, S. (1979). Unconscious fantasy and theories of cure. *J. Amer. Psychoanal. Assn.*, 27:579-596.

Bakhtin, M. M. (1981). *The Dialogic Imagination,* ed. M. Holquist, trans. C. Emerson & M. Holquist. Austin, TX: Univ. of Texas Press.

Balint, M. (1932). Character analysis and new beginning. In *Primary Love and Psycho-Analytic Technique.* New York: Liveright, 1953, pp. 159-173.

Brenner, C. (2006). *Psychoanalysis or Mind and Meaning.* New York: Psychoanalytic Quarterly.

Burke, K. (1935). *Permanence and Change.* Indianapolis, IN: Bobbs-Merrill, 1965.

Ferenczi, S. & Rank, O. (1925). *The Development of Psycho-Analysis,* trans. C. Norton. New York: Nervous & Mental Disease Publications.

Fonagy, P., Gergeley, G., Jurist, E. L & Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self.* New York: Other Press.

Frank, J. D. (1961). *Persuasion and Healing.* Baltimore, MD: Johns Hopkins Press.

French, T. (1958). *The Integration of Behavior, Vol. 3.* Chicago, IL: Univ. of Chicago Press.

FREUD, S. (1912a). The dynamics of transference. *S. E.,* 12.

——— (1912b). Recommendations to physicians practicing psycho-analysis. *S. E.,* 12.

——— (1915). Observations on transference love. *S. E.,* 12.

GLOVER, E. (1955). The therapeutic effect of inexact interpretation: a contribution to the theory of suggestion. In *The Technique of Psycho-Analysis.* New York: Int. Univ. Press.

GRAY, P. (2005). The analysis of the ego: inhibiting superego activities. In *The Ego and the Analysis of Defense.* New York: Aronson, pp. 103-127.

KLEIN, M. (1975). *Envy and Gratitude and Other Works: 1946-1963.* London: Hogarth.

KOHUT, H. (1984). *How Does Analysis Cure?* Chicago, IL: Univ. of Chicago Press.

LOEWALD, H. (1960). On the therapeutic action of psychoanalysis. *Int. J. Psychoanal.,* 41:16-33.

MYERSON, P. (1981). The nature of the transactions that enhance the progressive phases of a psychoanalysis. *Int. J. Psychoanal.,* 62:91-103.

NUNBERG, H. (1948). Problems of therapy. In *Practice and Theory of Psychoanalysis, Vol. 1.* New York: Int. Univ. Press, pp. 105-119.

O'SHAUGHNESSY, E. (1981). A commemorative essay on W. R. Bion's theory on thinking. *J. Child Psychother.,* 2:181-189.

RENIK, O. (1993). Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanal. Q.,* 63:553-571.

RICOEUR, P. (1970). *Freud and Philosophy,* trans. D. Savage. New Haven, CT: Yale Univ. Press.

SCHAFER, R. (1970). The psychoanalytic vision of reality. *Int. J. Psychoanal.,* 51:279-297.

——— (1973a). Action: its place in psychoanalytic interpretation and theory. *Ann. Psychoanal.,* 1:159-196.

——— (1973b). The idea of resistance. *Int. J. Psychoanal.,* 54:259-285.

SCHLESINGER, H. (2003). *The Texture of Treatment: On the Matter of Psychoanalytic Technique.* Hillsdale, NJ: Analytic Press.

STERBA, R. (1934). The fate of the ego in analytic therapy. *Int. J. Psychoanal.,* 15:117-126.

STERN, D. N., SANDER, L. W., NAHUM, J. P., HARRISON, A. M., LYONS-RUTH, K., MORGAN, A. C., BRUSCHWEILERSTERN, N. & TRONICK, E. Z. (1998). Non-interpretive mechanisms in psychoanalytic therapy: the "something more" than interpretation. *Int. J. Psychoanal.,* 79:903-921.

WINNICOTT, D. W. (1955). Metapsychological and clinical aspects of regression within a psycho-analytical set-up. In *Through Pediatrics to Psycho-Analysis.* New York: Basic Books, 1975, pp. 278-294.

---

*129 B East 71st Street*
*New York, NY 10021*

*Psychoanalytic Quarterly, LXXVI, 2007*

# PITY THE POOR PLURALIST

BY ARNOLD GOLDBERG

## INTRODUCTION

Imagine, if you will, that after a certain period of therapy that might range all the way from psychoanalysis to psychotherapy to cognitive-behavioral therapy on to psychopharmacologic treatment, we were able to determine fairly exactly that some particular neuronal connections in the brain were significantly altered. Based upon these alterations, we could further determine just how effective this or that particular therapy had been. In truth, as of now, there *can* be seen certain brain changes by way of PET scans after both psychotherapy and antidepressant drug therapy in patients treated with these modalities. Alas, it is only after talking to these patients to determine if they themselves claim improvement that we can make much of anything of these brain changes.

As eagerly as we long for some sure way of knowing if what we are doing is working, we have to fall back on merely asking. And even then, we cannot be sure. Some patients say they are better in order to please us. Some say they are not in order to hurt us. Sometimes we insist that patients are better in spite of contrary evidence. And sometimes we ourselves refuse to recognize improvement. So somewhere between those telltale brain connections and our own personal sense of certainty come the authors of this volume.

Rather than discussing each contribution individually, I should like to see the collection as representative of a long-standing prob-

---

Arnold Goldberg is a Training and Supervising Analyst at the Institute for Psychoanalysis in Chicago, and the Cynthia Oudejans Harris, M.D., Professor of Psychiatry at Rush University Medical School.

lem that has existed in psychoanalysis. The problem begins with analysts' expectations about just *what* psychoanalysis should do, along with the decision of *when* psychoanalysis should be considered. The background to this problem of decisions and expectations consists of the attitudes and training of these various contributors. The result of the very distinct differences of training and approaches presents itself as a problem for us all.

## THE GOALS OF TREATMENT

One would hope that the authors of these contributions would be of one mind in terms of the very issue, noted above, of our patients getting to feel better. Owen Renik begins his essay with such a declaration: i.e., one aims to afford the patient a feeling of greater well-being. He insists on this as universal. However, Marilia Aisenstein makes the familiar claim, one that most psychoanalysts have heard in extremis, attributed to Freud and later rather enthusiastically embraced by Lacan, that—on the contrary—insists that the analyst should *not* be interested in therapy per se.

Though it may be of some comfort to claim, along with Aisenstein, that we are primarily interested in the process, with improvement as a mere byproduct, it is difficult to collapse the analyst such as Renik who wants the patient to feel better, to remove symptoms, and so on, with the analyst who, in Rómulo Lander's quotation from Bion, wants the patient to "be what he is" (p. 1500). There is surely a certain vagueness in such a goal, and this vagueness is continued in this collection in the positions of Cláudio Laks Eizirik and Charles Spezzano, who claim, respectively, that being listened to somehow reduces psychic pain, and that redoing one's life story is equally effective.

In contrast to these unarguable but somewhat evanescent statements, R. D. Hinshelwood tells us that Klein advocated containment as a very specific process of modification of the patient's distress, and Kenneth Newman presents Kohut's position that a particular developmental process takes place in analysis, and this necessarily makes for symptom relief and health. Sander M. Abend

is a bit more cautious in championing Brenner's idea that the goal of treatment is but to alter those compromise formations that account for symptoms to those that afford more satisfaction of wishes. That last does seem to come closer to the Renik stance, but it is noteworthy that we start off with a medley of goals ranging from *helping* to *learning*. Our contributors are not of one mind.

In some sense, all our authors want to help their patients, but they vary greatly in terms of the level of their personal therapeutic zeal. It is, of course, unfair to focus on a few selected quotations. And, surely, not all the views presented here are in clear opposition, but they may serve to highlight one crucial distinction in terms of therapeutic action, and that distinction resides in a certain attitude that our authors present about their work. This attitude can be characterized in various ways—as, for example, one stance being a somewhat detached and intellectual exercise devoted to unearthing and exposing infantile conflicts, versus a stance that stresses an emotional involvement directed toward helping the patient better adjust to present life circumstances. Anyone reading these contributions is able to differentiate the author in terms of this attitude toward the work, and this is best seen in the differing discussions of just what each thinks about the *relationship*.

## THE RELATIONSHIP WITH THE ANALYST

Abend is clearest in his discussion of the analytic relationship, and he is equally clear in presenting his personal opinion about its usefulness and potential danger. He does not in any way diminish its significance, but feels it is not something he would champion as the major agent of therapeutic action. Renik takes a strongly opposing view in that he sees the analyst as a partner, as participant-observer, and as co-constructer of analytic material. He stands at a 180°-position away from Abend.

This discussion of the analytic relationship requires that one distinguish the usual analytic work of listening and interpreting from a more active participation and revealing of the analyst's own personality. This is not the same as the concern with understanding

and handling one's countertransference, which all the authors consider in some detail. Rather, it involves some crucial decisions about analytic neutrality and analytic enactments. In reading Spezzano's contribution, I find little doubt that he allows his own personality to be a part of his traffic with his patients, and one cannot help but feel the same about Aisenstein. Interestingly, Spezzano seems to place his behavior squarely in the center of his theory, while Aisenstein has a certain disconnect in her description of a fascinating clinical vignette and her advocacy of a theory that is neither Lacanian nor classical (and which in no way seems relevant to her vignette).

A similar contrast to that of Abend and Renik can be seen in the pairing of Newman and Eizirik. Newman presents Kohut's position as one that has the analyst functioning as a critical factor in filling in the uncompleted psychic structure of the patient. While this is said to take place within the confines of the selfobject transference, the various subsidiary contributors to self psychology all seem to concentrate on one or another actions of the analyst in terms of frustration and/or gratification, actions that seem, obviously, to go beyond the neutral stance of the analyst. Analytic neutrality, on the other hand, is underscored by Eizirik, who, while allowing for spontaneity and naturalness, emphasizes the need for a distance from the five points that he feels determine analytic work. One cannot help but see such a concept of "distance" as in opposition to that of frustration and/or gratification; there is no brief for co-construction in this stance.

Lander makes a distinction about the analytic relationship that differs from all the other authors' in that he differentiates neurotic from psychotic patients and recommends a pedagogic activity on the analyst's part. For Lander, the analyst teaches the psychotic analysand to survive. As a matter of fact, most analysts who stress the relationship as being itself therapeutic do tend to do a good deal of teaching and advising.

Hinshelwood considers psychotic patients as well, but in no way differentiates them from neurotic ones. He refers to Bion's treatment of a schizophrenic and links this to Klein's work with so-

called disintegrative egos. One striking difference between the authors who declare themselves as more or less following in the footsteps of Freud, and those who show more allegiance to Klein, seems to be in the consideration of treating neurotics and personality disorders, as opposed to psychotics. Kohut seemed to draw the line of analytic work at borderline personality disorders, while others feel analysis is indicated in these patients.

For the most part, the authors in this collection do not concern themselves too much with diagnostic categories or with the concept of analyzability. In reading these contributions, one cannot help but conclude that, no matter how much each lays claim to being a psychoanalyst with an allegiance to Freud, they are also quite different from one another. Identifying just what is the commonality and what is the difference seems to call for an explication.

## PLURALISM

At a recent conference of psychoanalysts, a clinical presentation was discussed from five different analytic perspectives. These perspectives were essentially presented as different theories, of both technique and therapeutic efficacy. This particular conference was an offshoot of an earlier one in which different ways and ideas about analysis were felt to be incompatible, and the resulting split in that meeting led to a new hoped-for unity, which lasted but a short while, until it, too, spawned first one, then two, and now five different sets of ideas and ways of thinking. One can fairly safely predict that some, if not all, of these five perspectives will undergo further refinements and generate offspring. Unity and single-mindedness do not appear to be happy members of the psychoanalytic enterprise. We sprout differences with abandon.

Pluralism is a philosophical doctrine that says there is no one principle that underlies all forms of thought. Thus, much like the overdetermination of behavior that is familiar to all psychoanalysts, there need not be a single explanation to encompass all theories or techniques of therapeutic action. Therefore, an improvement in a patient's well-being as a result of psychoanalysis can be

explained as a byproduct, a reaction to the warmth of the analyst's personality, a developmental achievement, an example of the efficacy of insight, a learning of how to handle discouragement, or all other manner of explanatory devices. All are capable of carrying the weight of explanation, but all are obviously not of one piece.

It is vital to clarify that pluralism demands more than a name change. Some essential differences must carry the weight of the separation of one idea about theory and technique from another. Sadly, many splits and changes are often more political than scientific, as time frequently makes clear.

Before further pursuing the answer to the riddle of such a disparity of explanations, we may find it worthwhile to examine its origin. One striking conclusion in reading these varied contributions is that no single author seems to be aware of, or at least to pay much attention to, any of the others. There exists a dogged insularity in each of these papers that, aside from a mere mention of what someone else may have written, follows a single line of conviction and conclusion. Indeed, some of the papers mention writers who are hardly household names, but who are brought forth as representative of something akin to a school of thought. Although Strachey is given more than his due, he mainly serves as a historical launching point to pursue what is likely to be a very regional set of ideas. A famous American politician, Tip O'Neill of Boston, once said that "all politics is local," and that quote might well serve to explain the psychoanalytic pluralism of today. It all seems to depend on where you live, who your teachers were, and who your personal analyst was. In other words, the pluralism that so reigns in psychoanalysis may well be more political than we would like to believe.

Lacan is a good case in point. His work is enormously popular in Europe, yet rarely taught in psychoanalytic institutes in the United States. His ideas about therapeutic action are almost incomprehensible to someone who follows Kohut. But Kohut is also a sterling example, inasmuch as his followers, for the most part, have little or no familiarity at all with the teachings of Bion about therapeutic change. More important, this insularity in psychoanaly-

sis is not only promoted, but is everywhere routinely perpetuated by an atmosphere of disdain toward the dissidents. It is extremely unusual to find an analyst who is familiar enough with the work of Bion, Lacan, and Kohut to be able to carry on a discourse about all of their thinking. Rather, we find analysts who are wedded to one or another, let us say, school of thought, and familiar enough with, let us say, the dissidents to brand them as such. Although this is a sad state of affairs, it merits something more than either disappointment or outrage; it calls for a study, and this valuable collection of essays is an excellent place to begin.

There are five clinical vignettes and a dream described in this group of papers. Although each is presented in order to illustrate or demonstrate a clinical application of the particular writer to his or her particular theory, it is not especially difficult to read them as illustrative of another of the writer's points of view. Aisenstein offers a vivid portrayal of an interaction with her patient Vanya. On one occasion, Vanya speaks of feeling forgotten and of thinking his analyst has disappeared. His analyst tells us of her worry about him and of his own disappearance. As an exercise, I read this vignette with Spezzano's point of view in mind—that of the analyst finding a home in the patient's mind and vice versa. I did this with no attempt to discredit Aisenstein's clinical work, of course, but rather to suggest that her efforts to connect what she does to the work of Green seemed no more telling than to a host of other writers.

Later in the same case, Aisenstein beautifully describes some post-analytic work (which, although it is given a French name, is hardly a particularly French activity), and so proceeds to make a statement about co-generated conclusions. Once again, I read this with Renik's very powerful insistence on the intersubjective nature of analysis, and wondered if the "theoretical" discrepancy might actually be one of language and vocabulary.

If we contrast the cases presented by Eizirik and Renik, we immediately note the active interventions of each of these analysts. One can read these interventions in a number of ways—as instances of countertransference, of self-revelation, or of introducing psychotherapeutic activity into a psychoanalysis. Likewise, one may

choose to rationalize what may otherwise be considered nonanalytic enactments by reference to learned scholars. Once again, we find that something that seems close to personal opinion or theoretical predilection inevitably comes to rule the day. It is not clear to the reader what guiding principle would allow Eizirik and Renik to come so alive with this patient and not with another.

It is apparent that many of these contributors do pretty much the same thing in conducting an analysis, but with different names and attributions. What is less apparent is how to determine when and why they do what they do, and if it always works. Again, this comment is not meant to argue with success as much as it is to wonder about failure.

And so to make a case for failure. My good friend Marian Tolpin, a distinguished analyst in her own right, once said that what we really need is a collection of and discussion about our failed cases. I believe that most of the initial presentations of innovative techniques and theories developed out of a lack of success with the tried and the true. Klein had to develop a different technique to deal with children, and I suspect this sort of impasse leading to creative expansion has been true of almost all the major contributors in psychoanalysis. I know this was the case with Kohut, who developed his ideas about narcissistic personality disorders because, for him, classical analysis seemed to fall short in providing a theoretical base for treating these cases.

Now, it is certainly fairly obvious that if all your cases do well and none is unsatisfactory, then you have no cause whatsoever to learn much about what others are doing. But if not, you surely have a debt to pay for your ignorance. And it seems more likely that the approaches of the contributors of this collection are best seen as working well with some patients and not so well with others. My reading of Lyotard (1984) and postmodernism is that there are no overarching theories that cover everything, but one needs to see what works best under what situations.[1]

[1] Kohut never meant for his ideas to replace those of Freud any more than, I believe, did Lacan; unfortunately, too many followers of post-Freudians have chosen to misunderstand that fact.

The position of Renik that rather dramatically describes how he helped his patient following his irritation at her whining is a wonderful example of local applicability. However, there may well exist a cohort of patients for whom such a theoretical and technical approach is contraindicated. But the conviction of Abend that belies the value of the analytic relationship seems to fly in the face of Renik's. Is it not possible that Abend is also correct, but again, only with selected patients? There is little doubt that both are sometimes right and sometimes wrong. Newman seems best in explaining this supposed dilemma in his presentation of the shortcomings of self psychology. In fact, shortcomings exist only in the usual overextension of all these theories and techniques. I cannot, for example, believe that Hinshelwood thinks Kleinian interpretations apply to everyone; but perhaps he does.

It should be clear that psychoanalysis has thus far been unsuccessful in answering the question of what works best for which patient. I cannot imagine how it will ever be successful in such a pursuit as long as we are prisoners of our parochialism. In Aisenstein's description of the case of Vanya, there is a sentence that describes their meetings as occurring three times per week, face to face. Aside from the unconscionable but true fact that this way of working would not be considered psychoanalysis in present-day accredited institutes in the United States, the intriguing question should really be just *why* and *when* this approach works best. Seeing someone three times per week face to face ought to be a decision based on more than convenience and cost, as important as these factors may be. There is now some developing research on the issue of frequency, and this needs as much investigative scrutiny as does the Lacanian technique of varying the length of the analytic session.

Once again, I believe much of this comes down to political rather than scientific opinion. I am not here calling for empirical research into various techniques, as desirable as that may be. I just doubt very much that there are any analysts who are familiar enough—say, with self psychology, for example—who are willing and able to practice that on certain patients, switch to Kleinian technique when that is appropriate for other patients, and then on

to Lacan or Bion for still others. My own admittedly limited contacts with analysts who are committed to, say, classical analysis indicates that they learn just enough self psychology to trash it, and just enough Lacan to dismiss him. That is the present sad state of affairs.

## AND EVOLUTION

I am emboldened to add a personal note to offer my own idea as to the explanation for the present state of seeming disarray in psychoanalysis. Knowledge, much like plants and animals in biology, undergoes an evolution of its own (Munz 1999). Knowledge generates a variety of ideas and concepts that enter the intellectual marketplace and aim to find niches for survival. Some concepts endure and some fail. A few, analogous to the Galapagos finches and turtles described by Darwin, manage to survive intact for fairly long periods because of their isolation from other sources of influx and influence. I suspect this may be true of our own islands of certainty where, for example, there is an insistence that one analytic theory and its interpretations apply to everyone, everywhere. Some theories have moments of extreme popularity, only to dissipate and disappear rather quickly, and so to be labeled as fads. All must ultimately face the crucible of public scrutiny and testing, and, ultimately, only the fittest survive.

It is important to recognize that we are living in the time of the evolution of psychoanalytic thought, and thus in a time that calls for maximal tolerance of diversity. Every idea deserves a hearing, no matter how foolish it may appear, inasmuch as evolution always proceeds by stages, and one can never predict the ultimate outcome that best serves adaptation. We should also remind ourselves that evolution takes a long time, and so we must suffer fools gladly and with patience.

## SUMMARY AND CONCLUSIONS

This collection of essays on the theory of therapeutic action from various theoretical and conceptual vantage points presents the

reader with a set of expert, varied, and well-thought-out guidelines. Each writer delivers what is an overview of how he or she works with patients, and much of this is offered in the spirit of ecumenism or universality. Just as we might appreciate from a collegial gathering of various religious faiths that emphasizes tolerance and respect for differing opinions, there seems little doubt that, in our hearts, we all know we are right. Thus, the stage is set for a struggle between opposing sets of truths, and the reader is given the freedom of choice versus rejection of each set.

My personal opinion is that the dictum of "In My House, There Are Many Mansions" is a mistake for our field, because, like it or not, most of us live in only one. We do occasionally gaze at and wave at our neighbors, but feel happiest at home. The comfort and security of sticking to one expert or one domicile is immensely increased by diminishing the attraction of any other. I recently attended a meeting devoted entirely to demonstrating that Kohut's ideas could be eliminated or seen as unnecessary by an exercise in extending some of Freud's ideas. I could not help but feel that this was such a wasted exercise that it should be left to theological debaters. The question remains: how do we best decide what works for which patient?

Pluralism answers this question by alerting us to the possibility that psychoanalysis must be seen as an evolving set of concepts with variable applicability. What psychoanalysis needs is genuine scientific pluralism. Given the unlikelihood of any one analyst's having familiarity with and competence in all the approaches presented in this collection—not to mention the approaches that have not been included—it seems that, in certain cases, the best we can do is to recognize our limitations and to refer the patient to one who has such competence. That, of course, demands enough familiarity with what others do to allow for reasonable exchanges. The publication of this volume is a step in that direction. Each contribution should be read as part of such a step and not as a "one-size-fits-all" program.

REFERENCES

LYOTARD, J.-F. (1984). The postmodern condition: a report on knowledge. *Theory and History of Literature, Vol. 10*. Minneapolis, MN: Univ. of Minnesota Press.

MUNZ, P. (1999). *Critique of Impure Reason*. New York: Praeger.

---

*122 South Michigan Avenue*
*Suite 1305*
*Chicago, IL 60603*

*e-mail: docaig@aol.com*

*Psychoanalytic Quarterly, LXXVI, 2007*

# THERAPEUTIC ACTION: CONVERGENCE WITHOUT CONSENSUS

BY JAY GREENBERG

It is seventy years now since Freud announced that the problem of the therapeutic action of psychoanalysis had been solved. Ignoring the heated controversies of the time (well illustrated by the papers at the 1936 Marienbad Conference), he characterized questions of how cure by analysis comes about as "a matter which I think has been sufficiently elucidated" (Freud 1937, p. 21).

Freud was keenly aware that the theory of therapeutic action is the pivot around which much of the conceptual structure of psychoanalysis revolves; more than just the nature of the psychoanalytic situation—crucial in its own right, of course—is at stake. Beyond that, our understanding of the nature of the mind itself hinges on how we think about the ways in which a conversation between two people can change the inner world of one of them (see Lear 2004). In light of this, it is easy to empathize with Freud's strategy, at the end of his life, of declaring victory and withdrawing from the theoretical battles in which he had been embroiled for so many years.

Today, as the papers in this issue richly illustrate, we do not have that luxury. In a psychoanalytic world shaped by a theoretical pluralism that is embraced by some analysts and reluctantly accepted by others, no formulation of the nature of psychoanalytic change is likely to go unchallenged. The problems begin with the

---

Jay Greenberg is a Training and Supervising Analyst at the William Alanson White Institute, New York, and Editor for North America, *International Journal of Psychoanalysis.*

absence of consensus about what the term *therapeutic action* means in the first place, and they ramify as it becomes apparent that each use of the term depends on the broader theoretical context within which it appears.

Consider Rómulo Lander's comment that "To discuss the theoretical problem of the mechanisms of cure demands that we first define the concept of *cure*" (p. 1499). This apparently simple statement parses the problem of therapeutic action into two separate questions: what changes, and what happens to create that change?

Personally, I have long believed that discussion of what changes in a successful treatment addresses the issue of the goals of psychoanalysis and not its therapeutic action (see Greenberg 2001, 2002). The two questions are different, although related; what we are trying to accomplish is bound to affect not only how we intervene with our analysands, but also how we judge the impact of various events that happen over the course of every treatment. These differences play a crucial role in shaping even how we *describe* the events of an analysis—which aspects of the analytic interaction we emphasize, which we marginalize, which we omit altogether. Freud's decision not to include his having fed herring to the Rat Man in his published account of the case, and his failure to relate the meal to the Rat Man's subsequent dream about herring, stands as eloquent testimony to how crucially values and theories affect descriptions of complex events.

The authors represented in this issue have vastly different ways of understanding the goals of psychoanalysis. Their various views can be arrayed, roughly, along a continuum from talking about changes that touch patients' ways of thinking about their own minds, to talking about changes that stress a new engagement with the object world. (There are multiple overlaps here, of course; I am highlighting what I see as nuances—different ideas about what is figure and what is ground.) Thus, several stress the way in which analysands arrive at a new relationship to their own experience; Sander M. Abend and Rómulo Lander, for example, emphasize an acceptance of personal history and the persistence of fundamental conflicts, an acceptance that opens the possibility of more satisfy-

ing choices. Marilia Aisenstein also talks about this sort of changing relationship to the analysand's own mind, but interpersonalizes it considerably: in her view (similar to Cláudio Laks Eizirik's), the analysand not only understands the experience that he or she brings into the treatment, but also develops new experience, co-created with the analyst.

Charles Spezzano and R. D. Hinshelwood move further toward focusing on the goal of new engagement with the other; for both, any learning about the analysand's own mind involves a new understanding of, relationship to, and internalization of the mind of the other. As Hinshelwood puts it, when the analyst interprets—giving the patient a more tolerable version of an unbearable experience—the patient also "receives something of the mind that did the modification" (p. 1491). For Hinshelwood, and equally for Spezzano (who feels that the core of what makes analysis different from philosophy or religion is the activity and personal availability of the analyst's mind), the goal is to build psychic structure by providing a new quality of relatedness. Note here the similarity to the goals formulated by Aisenstein and Eizirik, but with more explicit emphasis on the interpersonal dimension.

Kenneth Newman is even more explicit in proposing analytic goals that are organized around creating a new quality of object relatedness. Borrowing from Winnicott, he suggests that the goal of analysis is to facilitate the patient's ability to "use" the object, that is, to experience the other as both separate and available. Owen Renik goes furthest of all in defining psychoanalytic goals in terms of the patient's relationship to the external world. Reliance on what he calls "psychoanalytic goals" (p. 1550)—whether we understand these in terms of shifts in the patient's relationship to his or her own mind, or shifts in the nature of internal object relations—reflect reasoning that privileges the analyst's theory, and ultimately his or her authority. Renik's conclusion is that we are best served "by using the patient's experience of therapeutic benefit as the outcome criterion by which the success of clinical analytic work is judged" (p. 1550).

With so little common ground among the authors about the answer to Lander's question of what changes, it is not surprising that even the frames of reference for the discussions of how change comes about are so diffuse. This has, perhaps, always been the case. Discussions of therapeutic action tend to leave us with many more questions than answers, a conclusion that will be vexing to some analysts and stimulating or even reassuring to others.

But despite this, there is one respect in which the papers illustrate a broad convergence of views and signal an emerging sensibility that constitutes nothing less than a sea change in the way we think of what is essential in the psychoanalytic encounter. Although they agree on virtually nothing else (goals, etc.), at least six of the authors allude to the need for the analyst to step back from what he or she is doing and to examine *and change* something about the nature of his or her participation, because that participation—not merely something that is internal to the patient's mind—is blocking the possibility of analytic progress.

I will mention two examples of this, Eizirik's and Aisenstein's. Eizirik's example focuses on a lively and somewhat combative moment in which he is interpreting his analysand's conflicts about terminating her analysis, a rather long-range project. The patient says that perhaps she is in love with the analyst, which she immediately characterizes as a "joke" that would have been impossible for her to make earlier. The analyst works with that, relating it to the patient's feelings about her mother, and then points out that perhaps it is coming up because the summer break is only a week away. In response, the patient falls silent, and Eizirik notes a feeling of distance that contrasts with the liveliness of the session before he made this interpretation.

Eizirik thinks this through in the session, assumes that the deadness is explained by the fact that he was missing something—not, that is, by the patient's resistance—and comes up with a new interpretation: the silence derives from "the relation of the patient with her own internal frail and lonely child." He says something of this to the patient, and "this appears to bring us closer again" (p. 1475). The analyst attributes this changed tone in the session (a change

that he thinks of as progressive) to the fact that, by attending to the patient's response to the first interpretation (the silence and distance), he was able "to find the best way of identifying with the patient and . . . [her] internal reality" (p. 1476).

Along very similar lines, consider Aisenstein's reflections on the work with her patient Vanya. Aisenstein hears him arriving for a session, but he never rings her doorbell. Instead, he leaves a message on the analyst's answering machine, saying "You have forgotten me, and so I am going away." Rushing to her door, Aisenstein sees Vanya "running like a hare" away from the building (p. 1451).

As any analyst would, Aisenstein thinks about the preceding session "in as much detail as possible" (p. 1451). What stands out for her, however, is less about the analysand than it is about herself: she discovers a moment in which he irritated her. He had made a trip to New York to buy a painting, had returned to Paris on the Concorde in order not to miss an analytic session, and was complaining about his feelings during the trip home. In attempting to explore these complaints, Aisenstein asked why he had bought the painting, and the patient replied with a curt "None of your business" (p. 1452).

In thinking about this exchange, Aisenstein concludes that "the only condition I was aware of to which Vanya might have been hypersensitive was one stemming from the . . . emotions of the interlocutor" (p. 1452). The patient's actions and the emotions that drove them originated when he "sensed my [envious] emotional reaction to his account of the Concorde flight, but had been unable to express it to himself" (p. 1453).

Whatever the special sensitivities of Aisenstein's patient (and she suggests that he was especially sensitive), her example provides an excellent illustration of a more general point made by Spezzano:

> Given . . . that our minds are the tools through which psychoanalysis is applied to each patient in clinical work, it is inevitable that patients will worry if there may be something wrong with us that is interfering with, and will continue to interfere with, their getting what they need from treatment. [p. 1580]

Spezzano maintains that contemporary analysts of different theoretical persuasions believe that this is a *legitimate* worry, not a manifestation of endogenously determined resistance or of a transference that emerges unprovoked, irrationally distorting the reality of the analytic relationship. Supporting this generalization, he cites clinical vignettes from Mitchell and Steiner, who—despite basing their work in vastly different conceptual universes—both recognize the *clinical* need to back off when their analysands are frightened by, or otherwise unable to make use of, their interpretations. Although the point is not made explicitly, this backing off must involve the kind of self-scrutiny that both Eizirik and Aisenstein describe: the analyst looks to the nature of his or her participation, rather than to the patient's resistance or transference, in the attempt to understand and resolve difficult moments in the treatment.

Providing a conceptual scaffolding that would support just this sort of clinical choice was the fundamental reason that Kohut introduced the sweeping theoretical changes that made up his psychology of the self. In a broad statement that echoes what Aisenstein, Eizirik, and Spezzano prescribe, Newman notes that the theory of self psychology "has always recognized the patient's conflicts as not connected primarily to anxiety about infantile drives, but, instead, as emerging from a fear of being retraumatized by unresponsive selfobjects" (p. 1523). This implies that in the psychoanalytic situation, the analyst who is confronted by an anxious patient (or by some other manifestation of a stalled process) should look first to the nature of his or her participation in hopes of finding the cause and cure of the patient's difficulty.

Of course, this broad prescription does not tell us very much about what might attract the analyst's attention. Aisenstein's patient dashing away from the door is an extreme example, but the subtle deadening of the atmosphere in the room that Eizirik describes also needs to be sensed by an analyst inclined to attend to such changes. Consistent with his formulation of goals, Renik looks beyond the consulting room, examining his participation by judging it according to the extent to which the analysand is making changes

in his or her life—a criterion that would certainly be controversial among the authors represented here.

Both Eizirik's and Aisenstein's vignettes bring life to what has by now become a clichéd distinction between one-person and two-person models of the psychoanalytic situation. Each concludes that a regressive shift in the course of an hour implicates not just the patient's conflicts and compromise formations, but the analyst's participation as well. I suspect that each of the authors in this issue, with the possible exception of Abend, would agree with this way of looking at things. Spezzano is explicit about fears that the analysand will have about finding a home in the analyst's mind; the belief that the analyst must pay attention to the workings of his or her own mind as causes of the analysand's regression follows from this. Hinshelwood does not address the issue directly, but the same conclusion seems to follow—at least, implicitly—from his formulation.

This new perspective automatically brings new data to bear on our understanding of what happens in the analysis; once we adopt it, we cannot look at an analytic hour in the same way that we once did. But this is not to say that the change will end our debates about the nature of therapeutic action; the new data and new ways of thinking about them will change the nature of our conversation, but will not lead to consensus. An examination of Renik's clinical vignette—another example of an analyst shifting gears in response to noticing his patient's regression—will cast light on the persistence of the disagreements that have forever colored our conversations about the nature of therapeutic action.

Renik's patient Ellen comes into treatment for a depression, which Renik believes was largely caused by her inability to believe that she could have a satisfying relationship with a man, despite her strong desire for such a relationship. In an early phase of treatment, Renik and the patient work on her continuing, unconscious attachment to an angry, critical, narcissistic mother. Because she needed to maintain this attachment, "Ellen was obliged to find at least a measure of truth in the image of herself that she saw reflected in

her mother's eyes" (p. 1555); this "truth" included the idea that she could never be attractive to a man.

The patient improved symptomatically—she started to date—as she and Renik pursued the idea that Ellen's belief in her unattractiveness was driven by her need to stay close to her mother, and as she learned that mother's narcissism rendered any attempt at connection with her futile. In turn, Renik concluded that the interpretations he was making were correct, that the changes in Ellen's life were the direct result of the insights she was gaining in the analysis. This is a strong, clearly formulated view of therapeutic action: insight leads to change, and change itself is judged by improvement in the analysand's life outside the consulting room.

Here Renik shows little interest in the atmospherics of the treatment situation itself (although he does elsewhere—see, for example, Renik 1998); he does not attend to deadness in the room as Eizirik might, or to subtle changes in the patient's level of anxiety, or to the patient's fear of retraumatization, to use Newman's term. Instead, like Abend (and, in this respect, similarly to Eizirik), Renik focuses on the content of his interpretations and on what his patient is able to learn about herself.

Ellen's improvement continues for quite a while, Renik tells us, leading eventually to her meeting a man with whom a permanent relationship seems possible. But soon new symptoms appear: Ellen begins to worry that things will not work out, and she becomes preoccupied with hypochondriacal concerns about her health. The future of the new relationship is in doubt. On the basis of this turn for the worse, Renik concludes that the interpretive path he has pursued—tracing Ellen's anxieties to her need to maintain a fantasied connection to her critical mother—is no longer adequate. Further interpretations of Ellen's guilt over having caused her mother's illness and death also strike Renik as off target because they do not lead to any change.

At this point, for the first time in treatment, Renik becomes annoyed with the patient. His interpretations have an edge; he implies that he is skeptical about the sincerity of her guilty feelings. This raises, in the analyst's mind at least, thoughts about other

things that Ellen might be realistically guilty about. He tells her that "she really had done some things that weren't very nice" (p. 1558), focusing on ways that she had treated and mistreated her weak, disturbed first husband who was "only a kid when she met him" (p. 1560). Hadn't she wondered, he asks, "about the morality of her actions" (p. 1558)?

In the context of an ongoing conversation along these lines, Ellen's symptoms improve. Especially noteworthy is that she is able to "participate more happily" (p. 1561) in her new relationship. Eventually, she marries her boyfriend and terminates the analysis.

In his account of his work with this patient, Renik suggests that, because he kept an eye on the state of Ellen's symptoms, he was able to reflect on the interpretive line he was pursuing and to change it when it did not help promote beneficial change. In this respect, his approach is similar to Aisenstein's and Eizirik's; like them, he looks to his own participation and does not think first about the patient's resistance. More specifically, his thinking is similar to Eizirik's, because both monitor the *content* of their interpretations, whereas Aisenstein attends more to her emotional participation. Renik's emphasis relates directly to his view of therapeutic action—a view that, despite his quite different clinical style, is closest to Abend's among the authors in this issue. That is, Renik concludes from the changes in his analysand's life that he had found the correct interpretive line. As he puts it, the "changes confirmed the *validity* of our latest work" (p. 1561; italics added).

This is a bold assertion, one that gets to the heart of the dilemma we face when we attempt to theorize therapeutic action. Renik's account is succinct and coherent: when he was interpreting the patient's conflicts in one way, she failed to improve beyond a certain point; when he shifted his interpretive line, her life improved. The symptomatic change must reflect the workings of a newer, more valid understanding of the patient's inner world.

But as we all know, there is always more than one way to tell a story. Consider another, equally compelling understanding of what may have happened in the treatment as Renik describes it. This alternative narrative has nothing to do with the content—much less

the validity—of the analyst's interpretations. I am not proposing this alternative as more veridical than Renik's version, of course; the point I want to make, rather, is that *both* his account and my admittedly fantasied version are irrefutable on the basis of any available data.

Renik's patient, depressed because she cannot connect with a man and believing that her failure is due to her personal inadequacies, finds an analyst with whom she not only connects quickly, but who is willing to let her know that he sees her as an attractive person. Renik is commendably straightforward about this aspect of his work with Ellen. As he puts it, "She worried that by *encouraging her to think that she could be a desirable woman, I was engaging in wishful thinking, that I was selling her a bill of goods*" (p. 1555, italics added). As part and parcel of this encouragement, Renik takes a strong stance against Ellen's critical mother, going so far as to help her consider that "her mother simply did not love her" (p. 1555).

These interventions, irrespective of any insight to which they might lead, certainly offer the patient a relationship that is very different from the one she experienced with her mother. If we think of what the analyst is saying less as interpretations and more as relational interventions, he will be viewed as encouraging Ellen to attach herself to him in a way that allows her to embrace his vision of her and of her potential. As events bear out, from this new base, the patient is able to venture into the world in a new way, trying out new behaviors, beginning to date and eventually meeting the man she will ultimately marry.

But the new attachment to the analyst—despite its therapeutic effect—comes complete with its own stumbling block to further progress. By offering himself to the patient as a new, good object, Renik inevitably encourages her to mobilize splitting defenses; he invites the patient to polarize mother and analyst, past and present, attacks on the patient's sense of her own desirability and encouragement of it. It is likely that because of the splitting that gives shape to this new relationship, leaving treatment is inconceivable to Ellen; even if there is a decent, appropriate man available to

her, nothing can feel as good as what she is feeling in the treatment. As a result, just as she stuck to her mother for so many years, Ellen now sticks to her analyst and to analysis itself.

In fact, this may be the source of the annoyance with his patient that Renik reports. He would not be the first analyst who—having encouraged or at least tolerated the kind of splitting that leads to an objectionable positive transference—comes eventually to feel plagued by it (on the patient's behalf as well as his own). Looking at things in this way gives us a very different sense of what happened next. Specifically, it casts Renik's idea that Ellen "really had done some things that weren't very nice" (p. 1558) in quite a different light. Irrespective of what he calls the "validity" of this new interpretive line (i.e., providing Ellen with insight into the realistic source of the guilt that crippled her), it clearly conveys the analyst's own judgment that Ellen isn't nearly as nice a person (as desirable?) as they had both believed she was.

Thus, the home that the two of them had created (Ellen's home in Renik's mind, as Spezzano would put it) is no longer as safe as it once seemed to be. Ellen can no longer count on the comfort of her relationship with her analyst. Although it is not described in the report, her disillusionment must be powerful.

Disillusionment, while it can be crushing, can also be facilitative, a fact of life that has been widely noted by analysts of all theoretical persuasions. In the aftermath of disillusionment, people can or must take risks that had previously seemed impossible, including risking separation from the needed but disappointing other. (Developmentally, Kohut's concept of transmuting internalization—not to mention Freud's early idea that psychic structure develops when needs are not met—reflects this vicissitude of disillusionment.)

Renik tells us that it is in the aftermath of his annoyance with and criticism of Ellen that she was able both to embrace her new intimate relationship and to terminate her analysis. With this alternative formulation in mind, we can retell the story of Ellen's treatment in a way that has radically different implications for the theory of therapeutic action than those suggested by Renik.

On this retelling, a woman who feels undesirable meets a man who offers to help her understand the irrational origins of this feeling. The main reason to believe that the feeling is irrational is, of course, the fact that the analyst finds the patient attractive; this comes across both in his "encouraging her to think that she could be a desirable woman" (p. 1555) and in his attributing her inability to believe this to her continuing attachment to the critical judgments of a mother who was incapable of love. Having met this "new object," Ellen feels encouraged to move out into the world, actively, for the first time in a long time; she begins to date and even to attempt to create an enduring relationship with a man.

But, inevitably, she discovers that living in the world threatens her attachment to her new object in the same way that doing so once threatened her attachment to her mother. In the face of this, Ellen does what she always has done: she becomes whiny and hypochondriacal. Nobody, her behavior implies, would want her except her idealized analyst.

It is at this point that Renik lets his patient know that his belief in her desirability is not unconditional in the way she had hoped and thought it was. His disapproval shakes Ellen's hope that she had found a new and better home with him; she realizes that in her boyfriend she has a better alternative, and so she embraces what he has to offer and leaves the analyst (i.e., the treatment).

Putting things this way smacks of characterizing the effects of Renik's analysis of Ellen as a transference cure. But here we are faced with exactly the vexing problem of formulating a theory of therapeutic action. With enough creativity, an outside commentator can retell any account of any treatment in a way that makes it appear to be a transference cure.[1] Recently, under the influence of the pluralistic climate in psychoanalysis, and especially in light of what has been called *the relational turn,* we hear less about trans-

[1] Perhaps the greatest master of this sort of retelling is Levenson; see especially Levenson 1972.

ference cures. But, strikingly, the phenomena that the term was designed to describe have been incorporated into our way of understanding therapeutic action more generally. To an increasing degree, we hear claims that legitimate psychoanalytic change is driven by relational effects; recently, these claims have been bolstered by proposals that they have a structural, even neural basis in what has been called *implicit relational knowing*. All cure is transference cure; the new terms lack only the pejorative connotations of the old.

So how can we evaluate Renik's claims not only that he has "cured" Ellen because of the validity of his interpretations, but also that the cure itself demonstrates that validity? If we forgive him the circularity of his reasoning, his idea is certainly steeped in psychoanalytic tradition, and it coincides with the belief most of us embrace that the more we know about ourselves, the more effectively we will be able to live. But most of us also believe that people influence each other, for better as well as for worse, and that the workings of that influence are subtle, often covert, and always elusive.

And—crucial to any discussion of therapeutic action—even before we embraced (or reluctantly accepted) pluralism, we were committed to the concept of overdetermination and to the idea that any one perspective can never adequately explain complex phenomena. Perhaps it is fair to say that we tend to forget this commitment when we become embroiled in theoretical disputes that can, when we fall back on received doctrine, generate easy answers.

In contrast, at their best, conversations about therapeutic action remind us of the endless intricacy of the psychoanalytic process; they enliven our work and spark our attentiveness to events that would otherwise escape notice. These conversations should always raise questions about what we have done and how our acts have touched our analysands; they should remind us of the ineffable richness of every psychoanalytic encounter, and of the multiple ways in which we touch our patients' lives.

REFERENCES

FREUD, S. (1937). Analysis terminable and interminable. *S. E.,* 23.
GREENBERG, J. (2001). Thinking, talking, playing: the peculiar goals of psychoanalysis. *Psychoanal. Q.,* 70:131-147.
——— (2002). Psychoanalytic goals, therapeutic action, and the analyst's tension. *Psychoanal. Q.,* 71:651-678.
LEAR, J. (2004). *Therapeutic Action: An Earnest Plea for Irony.* New York: Other Press.
LEVENSON, E. (1972). *The Fallacy of Understanding.* New York: Basic Books.
RENIK, O. (1998). The analyst's subjectivity and the analyst's objectivity. *Int. J. Psychoanal.,* 79:487-497.

*275 Central Park West*
*Apartment 1 BB*
*New York, NY 10024*

*e-mail: Jayrgreen@aol.com*

*Psychoanalytic Quarterly, LXXVI, 2007*

# THE THERAPEUTIC ACTION OF PSYCHOANALYSIS: CONTROVERSIES AND CHALLENGES

BY OTTO F. KERNBERG

The eight papers gathered in this overview of the present-day stand regarding the therapeutic action of psychoanalysis appropriately represent the full range of contemporary psychoanalytic theories and approaches. They include the Lacanian approach as it has influenced Latin American psychoanalysis, represented by Rómulo Lander's paper; the mainstream French approach, naturally also influenced by (although critical of) Lacan, represented by Marilia Aisenstein's paper; the combined French and Kleinian influences on leading Latin American authors, represented by Cláudio Laks Eizirik's paper; the contemporary Kleinian school, dominant in Great Britain, represented by R. D. Hinshelwood's paper; the contemporary ego psychology approach, still strongly present in North America, represented by Sander M. Abend's paper; the growing influence of relational/intersubjective approaches combined with an ego psychological tradition in the United States, represented by Owen Renik's paper; the post-Kohutian self psychology approach, represented by Kenneth Newman's paper; and the American relational approach in its relatively pure form, represented by Charles Spezzano's paper.

---

Otto F. Kernberg is the Director of the Personality Disorders Institute at the New York Presbyterian Hospital, Westchester Division, New York; Professor of Psychiatry at the Joan and Sanford I. Weill Medical College of Cornell University, New York; and a Training and Supervising Analyst at the Columbia University Center for Psychoanalytic Training and Research.

Three major issues emerge in the study of these papers and, in this discussant's view, provide a frame of reference that permits their comparative analysis. The first of these issues is the question, "What factors are being proposed as the therapeutic action of psychoanalytic treatment that determine its outcome?" Clearly, the two dominant proposed factors are (1) interpretation of unconscious conflicts and meanings, and (2) the management of the interpersonal relationship established in the course of treatment.

A second important issue that emerges for comparison in each of these essays, and somewhat related to the first, is the influence of the severity and type of the patient's psychopathology on the specific modifications of technique proposed by several authors in this issue. That is, what intervention, whether centered on interpretation or on relationship management, is appropriate or not in relation to the degree of pathology of the patient. Third, there appears to be a relative absence of the distinction made between the various aspects involved in a therapeutically useful intervention: specifically, the theoretical orientation of the analyst, and the relationship between that orientation and the particular psychoanalytic technique expressed in his interventions, as well as the effect of that technical intervention on the psychoanalytic process, and the relationship between the psychoanalytic process and a specific and/or overall outcome of the treatment.

Perhaps—with the exception of Renik, whose paper deals with this third question explicitly—it is as if the relationship between theory, technical intervention, and overall outcome were taken for granted as self-evident. There is little empirical evidence available presently regarding these linkages, although we are beginning to see some empirical findings relating specific interventions to process and outcome. There is, however, undoubtedly, an enormous accumulation of *clinical experience* that justifies the authors of different theoretical approaches in proposing that their particular approach is linked to positive outcome.

One would expect that some attention may be given to what might be specific to the outcome with one theoretical approach as contrasted to others, or the limits of one approach regarding cer-

tain aspects of outcome. In fact, several of these contributors, particularly Lander, Aisenstein, Hinshelwood, and Renik, deal with some of these issues. Thus, for example, Aisenstein's agreement with Lacan's exclusive focus on the psychoanalytic process rather than on therapeutic outcome (Lacan in fact, suggested that a focus on the therapeutic effectiveness of what is being done may negatively affect the psychoanalytic process) stands in sharp contrast to Renik's focus on the therapeutic effectiveness of specific treatment interventions, using their very effectiveness as a criterion for the adequacy of these interventions.

The main emphasis in each of these presentations is, appropriately, what factors each of these authors considers to be the major therapeutic elements in his or her technical approach. From this viewpoint, one can order these contributions on a continuum from one polarity, which privileges interpretation as the salutary psychoanalytic intervention, to the opposite polarity, in which an appropriately managed relationship—including the interpretation of unconscious meanings of that relationship and the shared analysis of the contributions of the analyst to the developments in the relationship—is considered as the most important therapeutic factor in the treatment.

The Lacanian approach, at one extreme, is strongly represented by Lander and, to a lesser degree, by Aisenstein, in their view of interpretation of profound unconscious meanings as the dominant intervention strategy of the analyst; followed by the Kleinian and ego psychological approaches, still stressing the fundamental importance of interpretation leading to insight, represented, respectively, by Hinshelwood and Abend. Toward the middle of this continuum might be placed Renik, who, because of his emphasis on selective communication of the countertransference to the patient, appears radical from a traditional ego psychological and Kleinian perspective, but who still favors a strongly interpretive approach to the patients' material, as derived from an ego psychological background. Further toward the relationship-management polarity, one might place the self psychological approach presented by Newman, who believes that the analyst consciously assumes the position of a

selfobject and interprets from within this specific matrix of the analytic relationship, and the more extreme relationist approach represented by Spezzano, where clarification of the subjective experience of the patient in the light of the subjective experience of the analyst becomes a primary technique of therapeutic action.

Tangential to this polarity between the stress on interpretation, at one extreme, and on the relationship, at the other, is the growing awareness and use of countertransference as a characteristic of contemporary psychoanalytic technique In fact, while the development of knowledge and technical utilization of countertransference analysis has powerfully influenced the Kleinian and British Independent approaches, it has had much less impact on ego psychology and on French psychoanalysis, particularly on the Lacanian approach as represented in these papers. While countertransference may be used to interpret the present interpersonal relationship and thus becomes part of the intersubjective/relational approach, it may also be used to focus on particular aspects of the transference relationship, selectively utilized for transference interpretation, and not as an element used to stress the present intersubjective experience.

Before I explore each of the contributions of this monograph in detail, it must also be stated that most are characterized by a consistent, serious effort to explain their own viewpoints to a broad spectrum of psychoanalytic readers, be it by comparative exploration of alternative approaches, or by a clear statement of the background of the author's own approach. Jointly, they represent a condensed history of recent developments in psychoanalysis, and there is a refreshing lack of defensiveness about all of them. This discussant will try to stay within that spirit, although it seems only fair to start by spelling out my own particular biases.

As I have made clear in previous reviews of the literature on psychoanalytic technique (Kernberg 1993, 2001), I believe that a fundamentally interpretive approach constitutes the essential specific factor of psychoanalysis, and that the therapeutic relationship acquires specific features and a therapeutic effect in that context, precisely because it is used to interpret the patient's unconscious

conflicts in depth. As a consequence of consistent transference interpretation, the actual relationship with the psychoanalyst becomes a meaningful therapeutic factor.

I also believe that the traditional ego psychological effort to first foster a therapeutic alliance before interpreting the transference was a questionable one, and that, in this regard, the Kleinian approach to consistently interpret positive and negative aspects of the transference represents a more effective psychoanalytic approach. I think that the focus on the interpersonal relationship in order to correct past traumatic situations may interfere with the analysis of the corresponding profound transferences derived from the structuralization of authentic traumas of sufficient severity to distort the personality structure. An additional bias that I represent is the conviction that, eventually, empirical research will help to clarify some of these controversial issues and will provide important contributions to the development of psychoanalysis. This bias has influenced my stated concern about differentiating theory, technical interventions, process, and specific and nonspecific outcome (Kernberg 2004, 2006).

I have stated my bias to help the reader decide how much it may have influenced my critical review of these eight articles. Now let us review each of these contributions.

## RÓMULO LANDER'S PAPER

Lander's paper, "The Mechanisms of Cure in Psychoanalysis," to begin with, deals with the objectives of the "cure," drawing from Lacan and Bion in their emphasis on permitting the patient to "be one's self" (p. 1500). Lander points to Bion's statement that "being what we really are" (p. 1501) may collide with the moral values of family or society. He clearly differentiates the expectations of change in neurotic structure from what he calls "compensated psychotic structure" (p. 1501)—that is, patients who most likely correspond to what in another frame of reference may be considered borderline personality organization, whose defensive organization is not based on the mechanism of repression, and who present

an extremely frail ego prone to collapse under conditions of rejection. For these patients, Lander recommends "pedagogic activity" (p. 1502), or what might be called a supportive psychotherapeutic approach. Lander describes a third type of patient as exhibiting the "clinical syndrome of the hole," corresponding to a "narcissistic deficiency" and requiring "a permanent form of a transferential presence of the analyst's figure (or, perhaps, a substitute transferential structure instead, such as a new subject-idol in a religion or sect)" (p. 1502). These patients, therefore, require endless analyses.

The implication is, in this discussant's understanding, that only the first type of patients should be treated by standard psychoanalysis, and, in fact, the description of the mechanism of the cure that follows in Lander's paper is addressed to the technical issues presented by these more typical cases.

Lander considers that the two fundamental mechanisms of therapeutic action that permit the analysand's transformations are *insight or self-knowledge*, and *reliving or emotional experience*. In following Lacan, Lander suggests that the analyst's interpretation include both "a statement" and a latent content or "enunciation" (p. 1503) that permit the patient to construct his or her own interpretation on the basis of what the analyst has said. In his view, interpretations are helpful insofar as they lead to an interpretation within the patient's mind, rather than the simple acceptance of the cognitive statement communicated by the analyst. Regarding the second basic mechanism, that of reliving or emotional experience, Lander quotes Winnicott to point to the importance of regression that will facilitate an emotional experience and will avoid the patient's experience of the intervention as a purely intellectual one.

Lander comments on further aspects of the transformations that are desirable and should be achieved in psychoanalytic treatment. They include what Lacan calls *jouissance* (a concept that this discussant has difficulty in understanding fully). *Jouissance* refers to a sensual excitement or enjoyment, as opposed to profound and real pleasure. Such excitement, an aspect of psychic functioning, may become exaggerated to the extent that it produces a severe in-

terference with authentic pleasure, and, from that point of view, it needs to be differentiated from masochistic tendencies. Lander concludes, therefore, that *jouissance* needs to be brought into a certain appropriate balance at the end of the treatment.

He also refers to Lacan's "sexual phantom" (p. 1507) as the specific central sexual fantasy that may characterize and animate each patient's profound sexual life, and that, because of its perverse nature, is often repressed. Lander recommends, in agreement with Lacan, that this fantasy be considered a "treasure of sexuality" (p. 1508), and not as a symptom—not something to be interpreted, but rather to be accepted as part of the enjoyment of the patient's sexual life.

Lander also distinguishes the patient's identification with the analytic function from the identification with the analyst as the cure, stating that the former is the valuable one, while the latter corresponds to a non-analyzed resistance. This latter situation is an unresolved idealization of the analyst as the "subject supposed to know," and corresponds to the denial of the analyst's and the patient's castration. One objective of the treatment is that the analysand should accept both the analyst's castration (that is, accept the unrealistic nature of the idealized status), and his or her own equally incomplete state. The identification with the analyst as the one who knows constitutes a kind of transference cure, fragile and temporary.

Lander's combination of Lacan's and Bion's concepts clearly locates him in the camp of those who believe in the importance of interpretation as the central mechanism of therapeutic action, and to this he adds emphasis on the need for the emotional relevance of the interpretation as reflected in an emotional regression induced by it as proof of interpretive efficacy. His critique of the identification with the analyst as a transference cure is in sharp contrast to the view of relational psychoanalysts, and his distinction of various types of therapeutic intervention according to the severity of the patient's psychopathology tilts his view toward the ego psychological tradition. He explicitly distinguishes neurotic, psychotic, and perverse structures, and, as mentioned earlier, he does not believe

that standard psychoanalytic treatment is indicated for psychotic structure. Lander provides clarifying translations of Lacanian language into general psychoanalytic terminology, which in itself is a helpful contribution to his clear statement of his understanding of therapeutic action.

## MARILIA AISENSTEIN'S PAPER

Aisenstein's paper, "On Therapeutic Action," begins with an expression of skepticism regarding the possibility of carrying out "empirical" research (p. 1447) that compares alternative theories of therapeutic action and their corresponding technical implications. She states that, in practice, different theoretical approaches and their technical implications determine a disposition of the analyst to approach the patient's material in a certain way, which is influenced by the analyst's unresolved aspects of the transference to his or her own analyst and analytic school, and the deeper personality dispositions to the overall countertransference reaction of the analyst.

Aisenstein suggests that the combination of all these influences constitutes, at the end, "a *transferential-countertransferential, theoretical-clinical magma*" (p. 1448, italics in original). This magma, she proposes, provides a potential clinical "moment of reprieve" for two psychoanalysts speaking "foreign psychoanalytic languages" (p. 1448). The implication is that, while their theoretical formulations and theories of technique may differ significantly, psychoanalysts in their practical clinical interventions tend to find surprising similarities in actual reactions to the patient's material. Aisenstein suggests that unconscious elements of the countertransference, determined by all these components of the "magma," are an important aspect of both obstacles and creative surprises in analytic work. She stresses that what is therapeutically helpful is not the relationship with the analyst, but the communication by the patient of his or her fantasies, and, beyond the patient's awareness, of unconscious fantasies. This communication is met by the analyst's interpretations, which are formulated on the basis of a conscious elab-

oration of this material and the extent to which the analyst is aware of his or her countertransference, but also under the influence of unconscious countertransference elements that derive from unconscious messages from the patient that have not yet been deciphered.

The gradual working through of the patient's transferences by the analyst's bringing into consciousness those unconscious components of messages from the patient, and their countertransferential resonances as they are gradually clarified as part of the analyst's work, constitute the essential factors of therapeutic action. Here the stress is not only on interpretation, but, in an indirect derivation from Lacan's concepts, also on the unconscious messages that patient and analyst direct to each other—messages directly registered by and influencing the unconscious functioning of the other, in parallel to the communication of interpretations and their understanding and elaboration at a conscious level. Much of the work of grasping fully this material requires an *après-coup,* that is, a retrospective reorganization of material and experiences from past sessions.

Aisenstein stresses the importance of the contributions of Klein, Winnicott, and Bion regarding the concepts of projective identification and countertransference in a broader sense. She refers particularly to Green's concept of the transference as not only repeating unconscious material from the past, but reactivating "lacunae" (Aisenstein, p. 1450) in the patient's memory. These lacunae refer to early traumas prior to the acquisition of language, where recollection is impossible, and where the present transference situation serves to provide context for what Green calls "amnesiac recollection outside the field of conscious and unconscious memories" (Aisenstein, p. 1450). Aisenstein's stress on the function of the analyst, and the use of countertransference in a broad sense as an intuition of what could not have been mentalized, is related to her reliance on the retrospective reconstruction of past developments in the transference. The extended clinical example that Aisenstein presents beautifully illustrates all these concepts.

Having stated her own position, Aisenstein then critically reviews some basic Lacanian concepts. Regarding therapeutic action,

she agrees with Lacan's belief that "the psychoanalyst should be interested in the psychoanalytic process and not therapy" (p. 1456), and she states that this attitude is what clearly differentiates psychoanalysis proper from psychotherapy.

Aisenstein, then, is at one end of the spectrum regarding concern with process over outcome, and, as we shall see, Renik's position represents the opposite polarity: that of maximum concern with the relationship between process and outcome. Aisenstein objects both to Lacan's proposal that transference should not be interpreted because that would lead the patient to identify with the analyst's self, and to Lacan's disregard of countertransference. Aisenstein focuses on Lacan's stress that interpretations should not be directed at the secondary process (in other words, at a cognitive understanding), but that they should possess an associative and allusive character that would appeal directly to the primary process beyond the patient's cognitive grasp. Aisenstein is concerned about the exaggeration of this approach. She addresses herself to the secondary process, but, as do French analysts in general, attempts to make interpretations that are "unsaturated" enough to approach the primary process indirectly.

In a section toward the end of her paper, Aisenstein briefly reviews the complex changes that have occurred in French psychoanalysis since the end of the Second World War, the influence of British psychoanalytic contributions, and the original work from the Psychosomatic School of Paris and from Green. She seems to suggest, if I understand her correctly, that, as long as the analyst's attempt is to elucidate the unconscious reality of the patient by transference and countertransference analysis, as explicated earlier—with an attention to the process and not simply to symptom resolution—the treatment may be considered *psychoanalytic,* regardless of its formal features: whether it fits more into the frame of standard psychoanalysis or into that of psychoanalytic psychotherapy. She explicitly accepts the fact that patients with severe psychopathology may require a modified frame and frequency for the treatment, but that the basic difference stated above between psychoanalysis proper and all other psychotherapeutic techniques

matters. Psychoanalysis, Aisenstein concludes, is a unique way to help patients achieve both a deep knowledge about themselves and internal freedom.

## CLÁUDIO LAKS EIZIRIK'S PAPER

Cláudio Laks Eizirik's paper, "On the Therapeutic Action of Psychoanalysis," reviews central concepts integrated in his view of the psychoanalytic process, and explores the utilization of this process for the interpretive interventions of the analyst. These interventions center on the analyst's complex way of listening to the patient, and to the patient's listening to what the analyst is saying. This process leads to the discovery of new aspects about the patient that will further increase the patient's understanding of him- or herself, reduce psychic pain, and help the patient become more free to enjoy his or her capacities. Through the analyst's interpretations, the patient is thus able to gain insight as a result of being understood in a new, deep way.

Starting from Strachey's classical paper on the mutative interpretation as a source of reduction of superego projections, thus opening the patient's capacity for further communication, Eizirik then draws upon Klein's focus on the need for consistent resolution of paranoid and depressive anxieties in the transference, thereby developing the patient's capacity to work through the depressive position in relation to the termination of treatment. Eizirik agrees with Klein's emphasis on the rigorous maintenance of an analytic setting from the beginning of the treatment; he also agrees with Joseph's emphasis on nonverbal aspects of the patient's behavior in the session, the *total transference situation,* as well as the need to interpret the immediate transference situation with its full experiential implications. In further agreement with Joseph, Eizirik objects to expanding interpretation into the more general category of "plausible interpretations" (p. 1466) linked with the patient's somatic symptoms and/or past experiences, which creates the danger of intellectualization.

Here Eizirik introduces specific Latin American contributions, particularly the work of the Barangers on the analytic situation as a dynamic field, with the emphasis that the regressive situation of the analysis not only determines specific unconscious fantasies of the patient, but also specific unconscious responses of the analyst to the patient, which lead to a combined transference-countertransference fantasy about the analytic situation. This fantasy represents a new creation to which mostly the patient, but also the analyst, has contributed. The interpretation must fundamentally be directed toward the unconscious meanings of this analytic field in the here and now, as well as toward the implied relationship of the patient with the analyst. This approach requires an ongoing monitoring of the countertransference, utilizing Racker's clarification of concordant and complementary identifications in the countertransference, and also the Barangers' concept of a "bulwark" (p. 1468)—namely, a neo-formation around a shared fantasy of patient and analyst that may contribute to a stereotyped, imaginary role enacted by both of them.

Eizirik suggests that the patient's explicit discourse, the unconscious configuration of the analytic field, and the specific unconscious fantasy of the analyst at any given point all have to be included in the analyst's exploration of his or her reaction to the patient. Eizirik refers here to Faimberg's stress on the need to analyze the patient's interpretation of the analyst's interpretation in order to discover the patient's unconscious identifications activated in his or her way of listening. Eizirik outlines the material to be explored in the search for appropriate analytic neutrality, including the patient's material and transference, the countertransference, the analyst's value system, pressures from the external environment, and the analyst's theoretical orientation. He also underscores the importance of keeping a certain distance from these various determinants of the analyst's reaction.

In short, Eizirik stresses the importance of countertransference analysis, carefully differentiates it from the influences of the analyst's personality per se, and clearly enlists himself on the side of those who consider interpretation—particularly the systematic in-

terpretation of the transference and the transference-countertransference bond—as the essential instrument of therapeutic action. He outlines very clearly the contemporary Kleinian approach as enriched and modified by the Latin American experience, a still-dominant Latin American psychoanalytic development that may be contrasted to the parallel influence, as illustrated in Lander's paper, of the French, and, indirectly, of Lacanian approaches.

## R. D. HINSHELWOOD'S PAPER

Hinshelwood's paper, "The Kleinian Theory of Therapeutic Action," presents the historical evolution of Kleinian approaches. Hinshelwood starts out with a review of Freud's early development of ego psychology and the influence of Klein's analysis of children, focusing predominantly on the developing view of the transference. Hinshelwood summarizes the early differences between Kleinian and ego psychological viewpoints, in the sense that, from a Kleinian view, therapeutic change comes from insight into the specific roles and relations enacted in the transference, in contrast to the ego psychological approach, in which the objective is to help the patient's ego adopt new, more adaptive kinds of defenses and sublimations, and thus to strengthen it against the power of the instinctual id.

Hinshelwood refers to Strachey's pioneering idea that patients suffer traumatizing fantasies right now in the transference, and that the transference is a replay of pathogenic experiences in the past. Insight about the currently active fantasy in the transference may be contrasted with the reality of the interaction between patient and analyst. Juxtaposing reality and fantasy fosters the development of the reality principle, in contrast to a readjustment of the defensive structure. Hinshelwood then goes on to point to the importance of the changing concept and utilization of countertransference, and its problematic use, in some quarters, to share with the patient the emotional reaction the patient has induced in the analyst. Kleinian authors strongly objected to this practice because of

the risk of the analyst's acting out personal problems, and because transference analysis might be obscured by such communication.

Hinshelwood then refers to the developing differences between ego psychology and Kleinian analysis. Ego psychology, working from the surface of the patient's conscious experience, has carefully avoided early disruption of ego defenses, while Kleinian analysis, directly aiming at deep levels of anxiety, has been geared toward interpretively decreasing that anxiety while deepening an understanding of the patient. More recent developments of the Kleinian approach, Hinshelwood goes on, have been related to the analysis of countertransference in terms of cycles of projection and introjection—particularly projective identification—and the need to contain the patient's projected experience in order to return it to him or her in a form that has been modified by means of the interpretation. Here Hinshelwood stresses that "containing" refers not so much to the resolution of an intolerable conflict, but to the "repair of a mind" (p. 1492). He stresses that the increasing interest in Kleinian therapy has represented "a steady move from understanding conflict to understanding the way in which a mind fails to function and can disband itself" (p. 1492).

Hinshelwood refers to Bion's description of the psychotic mind and his differentiation between the nonpsychotic personality as concerned with neurotic problems and unconscious conflicts, on the one hand, and the psychotic personality concerned with problems of repair of the ego, on the other. Hinshelwood, quoting Bion in this respect, underlines that neurotic phenomena are concerned with repression, while the psychotic part of the personality tries to rid itself of the apparatus on which the psyche depends to carry out the repression. Implicitly, here Hinshelwood seems to move in the direction of a modified psychoanalytic approach, one that is indicated for patients with psychotic as opposed to neurotic structures —leaving open to what extent he is referring to particular psychotic dynamics in borderline patients or to psychotic illness in a descriptive sense, that is, the psychoanalytic experiences gathered with schizophrenic patients.

In the final part of his presentation, Hinshelwood generalizes the concept of the need to repair the mind by stating that, in the

treatment, the analyst is introjected not as a "good" object but as a "good understanding object" (p. 1493), and this is possible when intolerable mental entities have been modified by the analyst's understanding. The analyst's mind, in this respect, he says, is internalized as the function of understanding this bit of experience, and this brings about the patient's ego growth.

Hinshelwood refers to Bion's classification of the K-link, H-link, and L-link concepts (linkages in knowledge, hatred, and love) to suggest that this understanding function of the analyst brings about a K-link with the patient, to which the temporary dominance of L- and H-links are detrimental. Gradually, through interpretation, K-links become predominant; the internalization of the analyst's understanding good object leads to a strengthening of the patient's ego and to his or her capacity to deal with previously intolerable mental contents.

Hinshelwood refers to the general destructiveness involved in the ego's intolerance of aspects of psychic reality, and suggests that, in some patients, the ego is organized into two parts: a libidinal self and a destructive self. Even when this is not so, however, destructiveness must be examined consistently in the evolving transference-countertransference process. Disruptions of the K-link, when they occur, are a consequence of the activation of destructive processes that need to be understood and interpreted. All this constitutes the technical management of knowledge creation, which represents the therapeutic action of interpreting the deep destruction of knowledge and self-knowledge. It is the way in which the analyst's mind contains the knowledge of the patient's self-destructiveness that leads to this positive development.

As Hinshelwood shifts his perspective—throughout the paper—from analysis of neurotic to psychotic patients, and refers to the experience with schizophrenic patients developed by Kleinian analysts, he links his concept of *repair of the mind* with general psychoanalytic technique and the implied therapeutic action of psychoanalysis. It is not clear to this reader whether he sees this specific therapeutic action—that is, the increased tolerance of the ego to deal with self-destructiveness—as a general principle that ap-

plies to all patients, or whether he is referring to particularly difficult patients or those with severe borderline structures. This, of course, is a general problem posed by Kleinian psychoanalysis that, apart from assigning the designation of "pathological organization" to patients with narcissistic personality organization, is generally aversive to specifying psychopathological syndromes. This makes it difficult to judge whether Hinshelwood's proposed therapeutic action supersedes the resolution of repression in the context of the analysis of unconscious conflicts relevant for neurotic patients.

In any case, Kleinian analysis clearly stresses the importance of systematic analysis of the transference and considers the relationship between patient and analyst in terms of the analyst's incremental knowledge of the patient's thinking, with the purpose of that knowledge corresponding to an increase in the patient's self-knowledge, seen as intimately linked to the interpretive process. Kleinian analysis is critical of efforts to manage the interpersonal relation as a direct way to repair past traumatic experiences, or as an auxiliary tool to use in resolving unconscious intrapsychic conflicts.

## SANDER M. ABEND'S PAPER

In reviewing the history of theories regarding therapeutic action in "Therapeutic Action in Modern Conflict Theory," Abend presents a comprehensive, objective summary that grants its place to alternative theoretical developments while clearly outlining the evolution of contemporary ego psychology—also called contemporary Freudian psychoanalysis—in particular. Starting from the early development of the theory of therapeutic action formulated during Freud's time, Abend goes on to discuss the development of "theoretical variability" (p. 1425) during the 1960s. He points to several aspects of theoretical changes and new developments fostering that theoretical viability; first, he highlights the reconceptualization of the part played by countertransference in the psychoanalytic encounter, particularly under the influence of Kleinian authors. He refers to the general acceptance of the new, broader defi-

nition of countertransference, as well as the technical incorporation of countertransference utilization.

Second, the upsurge of interest in preoedipal development and its influence on neurogenesis and character formation come under discussion. This interest evolved under the influence of Winnicott and Mahler, among others, and related to the study of the limitation of ego capacities in certain analysands, particularly those suffering from severe psychopathology, and consequent evaluation of changes in the technical approach to them. Third, Abend notes, the developing interest in the influence of the realistic aspect of the relationship between analysand and analyst has evolved—within the ego psychological world, at least—in part under the influence of Loewald's concept of therapeutic action. Loewald pointed to the analyst's functioning in an analogous way to the mother of a developing child, in helping to articulate inchoate aspects of the analysand's unconscious mind. Finally, Abend goes on, the "assault on positivism" (p. 1427) was expressed in questioning the analyst as a scientific observer capable of arriving at reliable, objective judgments about the nature of the patient's psychic reality.

Against this background, different viewpoints have evolved: Abend refers to the tendency to question the authority of the analyst as an objective judge of the developing intersubjective aspects of the psychoanalytic situation, and the related tendency to question the privileged nature of the analyst's observations—in contrast to an equally privileged view of the patient's experiences in the analytic situation. This viewpoint evolved into the general relational psychoanalytic perspective, to the extent of granting, in some quarters, a dominant, privileged view to the patient. Deriving also from contributions by Winnicott, Modell, and others, a subtle variant of the corrective emotional experience has evolved, in the sense of advocating a modification of the analyst's behavior toward patients who exhibit particular deficits stemming from preoedipal stages of development. Again, this trend has tended to stress the importance of the analytic relationship, in addition to supporting an interpretive approach. In a completely different direction, the Kleinian focus on the use of the analyst's countertransference

gradually expanded its influence into the ego psychological approach, as can be seen in Sandler's concept of role responsiveness and in Jacobs's work.

In contrast to these developments, Abend refers to newer ones in the ego psychological approach, particularly those seen in the work of Arlow and Brenner, who maintained the view that the analyst's observations, with all their limitations, do have an objective basis that permits detection and interpretation of the components of the patient's unconscious conflict by careful study of the analytic material, "including, but not confined to, the transference" (p. 1432). Abend mentions Brenner's critique of efforts to strengthen the therapeutic alliance by making changes in standard analytic behavior, seen "as actually liable to constitute invitations to subtle enactments, whose unconscious meaning might escape full analytic scrutiny" (Abend, p. 1432).

Abend also refers to Brenner's assertion that "the proof of any theory of therapeutic action cannot be demonstrated. Instead, it is only possible to observe and describe certain changes that accompany improved functioning in patients" (Abend, pp. 1432-1433). These changes consist of the substitution of new compromise formations for the more pathological ones they replace—ones that will permit more gratification and less dysphoria and/or self-punitive behavior. Abend notes that Brenner—as well as other ego psychologists of the traditional approach—continues to stress that changes are brought about by the gradual acquisition of meaningful insight, although the relationship with the analyst is also meaningful and influential in bringing about change. Abend expresses his critique of the relational approach as "consistent with the longstanding historical trend to deemphasize the central importance to analysis of sexual and aggressive conflicts in favor of increased attention to preoedipal developmental issues" (p. 1433).

Abend then addresses Gray's contribution to ego psychological technique through his study of the defensive aspects of the patient's communication, viewed as reflecting conscious or unconscious anxiety at the prospect of revealing certain charged mental contents in the presence of the analyst. Abend notes that this fo-

cus on defense analysis, with an emphasis on transferential aspects of the concern about the analyst's judgmental reactions, may become the centerpiece of analytic work. The assumption is that this process brings about the analysand's gradual acquisition of an enhanced freedom to admit to consciousness thoughts that are linked to desires or emotional attitudes previously regarded as dangerously unacceptable.

Abend ends by expressing his agreement with Brenner's formulation that instinctual conflict is never completely abolished—that it remains as a permanent and ubiquitous feature of human mental life; but it may be expressed in compromise formations that are more effective, with the favorable results of symptom reduction, improved object relations, and an improved relation to reality in general. Abend concludes his comprehensive analysis by pointing to the two major aspects of the psychoanalytic process assumed to be related to its therapeutic action: namely, *insight* and *the analytic relationship*. While accepting the importance of the analytic relationship as a factor that contributes to therapeutic action, he stresses insight derived from interpretation as the most important factor. Although his emphasis on transference analysis is less categorical than that of the Kleinian approach, contemporary ego psychology and contemporary Kleinian analysis both strongly support the use of interpretation—and particularly the interpretation of the transference—as the major therapeutic feature of the analytic process, leading to insight and, as a consequence, to therapeutic change (whichever way a particular author may define it).

## OWEN RENIK'S PAPER

Although in many ways, Renik maintains a technical approach closely linked to an ego psychological tradition, in reading his paper, "Intersubjectivity, Therapeutic Action, and Analytic Technique," we enter what may be broadly called the field of the intersubjective/relational theories. Renik starts outs by making a strong point: the objective of all psychoanalytic approaches is for patients to feel better—to feel more satisfaction and less stress in their

lives. Renik suggests that, while different theoreticians explain such improvement in terms of their assumptions about changes in psychic structures, the end result, in the light of the patient's experience, is the same. He proposes that the differences do not pertain to the therapeutic effect itself, but rather to the method of how to bring about that therapeutic effect.

Renik suggests that a reconsideration of analytic expertise and authority is called for. He argues that the analyst, instead of being an authority who reveals hidden truths to the patient, is a partner who works with the patient to create understanding concerning the way the patient constructs his or her reality, and to revise it so as to afford the patient less distress and more satisfaction in life. Renik suggests that in a successful clinical analysis, co-created old truths are replaced with co-created new truths. The vehicle for collaboration, he goes on, is the dialogue between patient and analyst. He proposes that there is a need to establish outcome criteria for clinical analysis that are independent of psychoanalytic theory, and that psychoanalytic purposes are best served by using the patient's experience of therapeutic benefit as the outcome criterion by which the success of clinical analytic work is judged.

Psychoanalytic propositions, Renik goes on, can be tested by measuring a dependent variable: valid insights are the ones that produce enduring therapeutic benefit; useful analytic techniques are the ones that produce valid insights. If a better understanding that is reached between patient and analyst is not accompanied by a subjective judgment of increased satisfaction and decreased distress on the patient's part, the validity of the understanding—its completeness, at least, if not its accuracy—must be doubted.

Renik refers to the intersubjective or relational orientation as not indicating, in itself, an altered conception of the therapeutic action of clinical psychoanalysis, but an increased appreciation of the epistemology of the clinical analytic encounter. And that has decisive implications for how an analyst goes about arranging for the therapeutic action of clinical analysis to take place—that is, for his or her theory of technique. Renik proposes that different narratives derived from different psychoanalytic techniques may be

adjudicated on a pragmatic, empirical basis, i.e., that an experimental situation may be established in which narratives can be evaluated according to their ability to predict a given outcome. The narrative is the independent variable, and the therapeutic outcome is the dependent variable that may scientifically validate, or not, a particular narrative. Thus, Renik points to both the value of empirical research for his particular approach, and to its clinical utilization, that is, an approach that tests its utility by examining its therapeutic effects.

Renik presents an extended case summary that illustrates his interpretive approach. He describes the lack of effectiveness of a certain set of interventions, although they seemed eminently reasonable and appropriate to both him and his patient, and he relates that, by utilizing his countertransference reactions and the patient's lack of improvement in a central area of her difficulties, he gradually came to discover other, previously unexplored aspects of her conflicts and her relationship with him in the transference. This permitted what he considered an appropriate modification and completion of his analytic approach to take place, and led to significant amelioration of a basic problem in the patient's life.

A crucial moment of this case's development was an intervention by the analyst under conditions of his feeling irritated because of the patient's manifestations in the transference. He confronted her with the contradiction between her continuous expression of guilt feelings in a general way, while she simultaneously avoided any focus on concrete areas where, from what she had mentioned to the analyst, one could raise questions as to whether she might have treated others rather badly. The patient at first had a hard time understanding what the analyst was talking about, continuing to express her feelings of guilt, but without taking up the analyst's comment. He pointed out her denial that, at times, out of desperation, she had victimized others. To this, the patient reacted with intense agitation and depression. The analyst felt that she was now beating herself up in a plea for sympathy in order to ward off genuine self-criticism, with the hope of being reassured by the analyst, and he indicated this to her.

At that point, the patient became motivated to "confess" issues regarding her marriage that she had not shared with the analyst before, and this led to a reexamination not only of the relationship with her husband (whom she had divorced years earlier), but also of the relationship with her present boyfriend. This example thus illustrates the connection between what Renik considers a therapeutic intervention and its effect on the patient's functioning.

It is possible in any case presentation, of course, to suggest alternative ways in which one might handle a particular development in a session. This discussant's interest, however, is in what he considers a very appropriate confrontation by the analyst, even if it reflected a partial acting out (as Renik himself observes) of his countertransference: the follow-up interpretation and the overall effects of his interventions confirmed his hypothesis.

This case does not illustrate something that Renik has advocated elsewhere (Renik 1999)—namely, not only a communication of the countertransference per se, but its utilization as part of a confrontation of the patient's behavior toward the analyst in the session. However, it does illustrate a general proposal that is of significance for the entire discussion of the therapeutic action of psychoanalysis—that is, the direct, concrete relation between process and outcome. It would seem only fair to state that, probably, for most analysts, the focus is so predominantly on the process that its immediate effect on general outcome tends to receive much less attention.

There is, however, an unavoidable question raised by all our interventions, namely, the extent to which they affect the patient not only in the session but outside the session as well. In other words, the short-term, immediate effect of therapeutic interventions is an important clinical feature, and the exclusive focus on long-term outcome obscures the need to study the relationship between theory, technique, process, and immediate effects of our interventions. Regardless of where one stands in connection with Renik's particular case illustration, it should be noted that the concern with the relationship between process and outcome is merely explicated in this specific example, and is not further elaborated.

## KENNETH NEWMAN'S PAPER

Newman's paper, "Therapeutic Action in Self Psychology," presents a comprehensive, updated review of Kohut's and post-Kohutian self psychology from the viewpoint of the proposed therapeutic action of this approach. The paper begins with an overview of Kohut's theory of the effect of severe environmental traumata on the establishing of a normal, cohesive self, and the need of narcissistic patients—typically suffering from a pathology of selfobject relationships—to complete the underdeveloped, traumatized, early self structure. The traumatic etiological impact derived from empathic failures of parental figures determines the need to find what Winnicott considered a "usable object" (Newman, p. 1515): this usable object corresponds, Newman suggests, to Kohut's selfobject.

In the case of selfobject failures, the archaic, grandiose self of the traumatized individual cannot be modulated and integrated, fueling ego-syntonic ambitions and aims and serving as a continued source of self-esteem. The failure of the idealized parent to permit the infant and child to regulate tension and affect activation, and thus to become a bearer of admired standards, causes the child's self to remain in an archaic form, leaving him seeking restitutive means to maintain homeostasis through addictions, perversions, and delinquency. Under these conditions, in the treatment, the analyst must legitimize the patient's claims for responsiveness to fill in an incomplete psychological structure and to validate the significance of emotional requirements. This viewpoint brings about a different analytic experience, distinct from what Newman calls the "experientially adversarial" (p. 1517) analytic position in the exploration of "resistances." Instead, the analyst here provides the missing complementary selfobject experiences and idealized selfobjects. In short, the analyst should accept these narcissistic transferences, allow them to unfold, and not challenge them as defenses against primitive drive-superego conflicts.

The central aspect of therapeutic action, in Kohut's view, Newman goes on, is the accretion of structure via optimal frustration of the analysand's needs, aided by an empathic surround, mediated

through the analyst's optimal use of interpretation. The analyst's response includes legitimizing the patient's distress upon the reactivation of old unfulfilled needs and temporary failures, or upon inevitable breaks in empathy within the current transference. Newman states that the repeated process whereby the patient's current injury is understood as embedded in the continuing need for selfobjects, now frustrated by a break in the relation with the analyst, provides an opportunity for the patient not only to feel a sense of repair, but also to gradually internalize this experience. In this manner, patients can begin to help themselves as they take over the analyst's function.

Newman then goes on to discuss contemporary issues of self psychology. He points to the fact that narcissistic patients defend themselves against the reactivation of the traumatizing affect state linked with the actualization of their experiences of failure by unresponsive selfobject or idealized objects. When these defenses against the actualization of retraumatization by the failures of mirroring and idealizing needs are aroused, the patient will have to maintain these defenses against intolerable affects linked to those traumatic circumstances. The self psychological approach, therefore, also analyzes defensive structures in these patients, namely, those erected against the actualization of feared, previously traumatically experienced needs.

It is important for the analyst, under such circumstances, to maintain a consistently empathic response to the patient, in contrast to the relational analyst's co-construction of transference-countertransference analysis by sharing with the patient the analyst's emotional reaction to the patient's behavior. Interpretations formulated in the process of exploring such defenses against the enactment of traumatic states need to be embedded in an empathic surround. In the treatment, it is important to create the conditions for mobilizing earlier expressed needs and their frustration onto the analyst, who can utilize these activated needs to set in motion transformational processes, and thus help rework unresolved negative transferences. The analyst, through the careful process of analytic work, becomes a usable object—or a usable selfobject.

Newman stresses the importance of the activation of primitive affects as part of the unavoidable frustration of the patient's selfobject needs at times of inevitable failure of the analyst's empathic process. Such archaic, unintegrated, potentially overwhelming affects require, Newman suggests, that the analyst include the language to address a range of emotional states that result from early selfobject failure. The analyst needs to carry out a "holding" action to survive the intense negative affects of these patients at such points, thus permitting a new integration to take place. At such moments, the patient experiences "fragmentation anxiety" (p. 1534), that is, lost connections to needed selfobjects, because this situation not only entails the loss of essential ties, but also the overwhelming, disruptive experience of painful affects that threaten the integrity of the self.

Here Newman introduces a new concept to self psychology. He proposes that the yearning of the patient for a mirroring or idealizing selfobject evolves in parallel with the evolving need for the selfobject associated with containing and regulating affect. "Hungering" for objects to fulfill his or her needs, the patient who was severely traumatized in the past was left as an injured child, with a concretized internal picture of a "negative selfobject" (p. 1536). Newman suggests that under such circumstances, when critical needs or disruptive states are experienced, the patient fears reactivating this negative selfobject. Such negative selfobject images derive from the parents' unavailability or excessively critical attitude, or from parents who were excessively injured by the child's intense hostility or depressive affects.

Newman thus proposes that what interferes with the activation of deeper transference states is not only the memory of having been misunderstood or criticized for selfobject needs, but also the fear of reencountering the toxic objects—what the author calls negative selfobjects. At such points, the patient also has intense fears of his own destructiveness to the self and to the other, and it is important that the caretaker survives the destruction (in Winnicott's terms). In short, in Newman's view, when the double function of the analyst of the narcissistic patient—which is to provide missing

selfobjects and to contain the activation of intolerable affects and of the related negative selfobject in the unavoidable retraumatization when deep failure of self-cohesion occurs—has been carried out, this constitutes the central mechanism of therapeutic action within a contemporary self psychological approach.

It must be pointed out that this presentation refers to the proposed therapeutic action of the technical approach to a specific type of patients, those with severe narcissistic pathology. It raises the interesting question of to what extent different technical interventions are required for different types of psychopathology—a point raised in the presentations of Lander and Hinshelwood as well. This question, naturally, is also connected with the extent to which different interventions refer to interpretive or relational interventions. It seems fair to remind the reader that, insofar as the self psychological approach to narcissistic patients implies an active identification of the analyst with the function of the patient's self-object, the analytic relationship is already marked by a particularly constructed interpersonal relation that has a central therapeutic function as its aim. However, as Newman acknowledges, the self psychological approach also presents significant differences to the relational approach, in general.

## CHARLES SPEZZANO'S PAPER

This brings us to the last of the essays in this issue, by Spezzano, on "A Home for the Mind," an overview of a relational approach to the question of the therapeutic action of psychoanalysis. Spezzano proposes that the central aspect of the therapeutic action of psychoanalysis is the possibility of the patient's finding a "home" for his or her mind in the mind of the analyst, from which to be able to share with the analyst what is going on in his or her mind, and to have the analyst react to this by accepting into the analyst's own mind what the patient is communicating. In the process, the analyst reorders in the analyst's own mind the characters received, in terms of the analyst's personality and in terms of his or her place in the psychoanalytic community.

The psychic home of the analyst is his or her psychoanalytic theory and the community that represents it; these constitute a team in his or her mind to which the analyst belongs, and this helps the analyst formulate thoughts that clarify, in the light of this theoretical team, the patient's sharing of the characters of his or her own mind. The analyst's subjective reaction, which derives from his or her personality and relationship with the patient, also plays an important role.

Spezzano formulates the content of the patient's mind and of his own mind as characters or teams of characters that interact, which may be the source of gratification, conflicts, anxiety, and inhibitions. The analyst may use theory, but it has to come into play almost automatically, in the context of his or her emotional reactions to the patient. Spezzano agrees with Poland that the deepest level of therapeutic action is one in which the analysand not only utilizes new understandings in ways that show up in consistent changes of character and mental functioning, but also does so without being aware of using them or without having to think consciously of using them. The analyst uses his or her spontaneity, in which things "emerge into consciousness" (p. 1573), in responding to what the patient presents to him or her—to, that is, the mind of the analyst.

Continuing in his metaphorical language, Spezzano suggests that, "as the mind of the patient [is] unpacking itself" (p. 1571), showing itself, being shown to itself by the analyst, it finds undeveloped, repressed or projected parts of the self in the interchange with the analyst, in taking new parts from the analyst, and subsequently in leaving. This permits the patient's mind to be more emotionally alive in the world of other people. Spezzano, we might say, carries out character analysis in an object relational frame of psychoanalysis that analyzes the characters the patient has created to represent his or her experience. He invites the patient to use the analyst as an audience, to allow him to re-create new scripts for the patient's characters, to introduce new characters, and to treat them as mutable creations. As a result, the ensemble of inner

characters of the patient will have changed, offering new roles for the patient and new views of others.

In considering clinical case material presented by analysts from different approaches, Spezzano notes that it is sometimes evident that, from the viewpoint of those different approaches, or in the context of very different interpretations of the process, patients are being helped, and this may be offered as evidence of the advantage of a particular approach. At the same time, he also refers to the difficulty in communicating directly at the level of such theoretical approaches. Spezzano seems to be saying that it is not very useful to discuss how analysis works, and that there is evidence that patients improve when all variations of it are utilized. In his view, analysts of different persuasions play the analytic game differently, but whatever each one does, that is what the patient has a chance to get better with.

Spezzano's own theoretical approach, as mentioned earlier, is inclined toward aspects of psychoanalytic theory that focus on representations taking the form of interacting characters, and he formulates his observations by thinking about himself and others and by living through internal interpersonal stories (representations that take the form of self and others interacting in affectively charged dramas). Spezzano states that one may also experience moments of complete alienation from one's own body, from one's relationships with self and others—dreamlike states of the patient to which the analyst may respond in an interpretive way that relates to these dreamlike moments as dream fragments. The analyst may associatively play with a word or phrase of the patient at that point.

In referring to patients whose main interest or worry is about the analyst's mind, Spezzano mentions that such patients are labeled in the literature as "thin-skinned narcissist[s]" (p. 1580) and borderline patients, and proposes that these labels have arisen, at least in part, in response to our discomfort with patients who pursue these concerns in a demanding, annoying, desperate, or attacking way. He quotes Steiner's concept of *interpreting in the projection* —that is, making an analyst-centered interpretation—as an illustration of the interaction with this kind of patient. Spezzano stresses

the importance of taking seriously the patient's worry that something is wrong in the session, in the relationship, or in the analyst's mind, "because it allows the patient to move around the co-inhabited psychological space with less fear of bumping into mysterious and dangerous things in a dark room" (p. 1581).

In the last part of his paper, Spezzano classifies scenes involving analysts and patients as reflecting constant human conflicts between Eros and power—in other words, between analyst and patient uniting into a team, as contrasted with analyst and patient coercing each other with the power of rhetoric and emotion. Analysts and patients working as an Eros team search for what is repressed and missing.

Naturally, destructive parts of the patient are sometimes placed in the analyst's mind and then return to the patient from without. Spezzano suggests that this does not involve the mechanism of projective identification, but rather it is a function of the patient's intolerance of locating this destructive aspect in his or her own mind, and as a result, the patient fantasizes that it comes from the mind of the other. This experience is a mental function available to the analyst, but not to the patient. The disturbance caused in the patient by its appearance is due to it being foreign to the patient, and some patients feel that they are then outside the play of Eros, within which human teams are bonded, and, in the patient's fantasy, the patient has access only to power as a way to relate. And this power is willed, expressed by the patient as a demand to be let onto the analyst's team and as a concern about whether the patient is being included or excluded.

Spezzano concludes by stating that one aim of analysis might be described as the patient's better toleration of the anxiety and pain of being on the human team. A lack of ability to be drawn together in an Eros-driven union, and an incapacity to experience self and others as not simply trying to gain power and control, is seen not only in patients, he concludes, but also in analysts' efforts "to gain power and control over that thing of Freud's called psychoanalysis" (p. 1582).

Spezzano's approach is clearly representative of relational psychoanalysis, although relationally oriented analysts also represent a spectrum, of course, rather than a narrowly defined, unified theoretical approach. This is true, naturally, of all the approaches represented in this issue. What makes it difficult to highlight the specific aspect of Spezzano's approach as presented in this paper is his consistent use of metaphor, and his almost playful way of dealing with psychoanalytic concepts and controversies. These attributes make the paper eminently evocative and readable, but difficult to synthesize beyond the clear sense that he illustrates an approach very much centered on the analysis of the relationship between patient and analyst, with a degree of freedom on the part of the analyst to communicate his or her emotional reactions to patients at points of dreamlike regression, and with little reference to the patient's unconscious past. This approach seems general enough so that all kinds of interpretations, consideration of oedipal and preoedipal, aggressive, and sexual issues may be involved in the "play of characters," but there is also enough lack of precision in the general statements and the brief case vignette to make it difficult to go beyond that.

Spezzano conveys an attractive warmth and sense of humor, and it would be fascinating to be able to clarify his view of the therapeutic action of psychoanalysis with more extended clinical material as an illustration of specific aspects of his interventions that may contrast with those that are more common to the broad spectrum of psychoanalytic psychotherapy.

## SOME FINAL THOUGHTS

The review of these eight essays has illustrated, I believe, the fact that our theories of therapeutic action, at this point, center around controversy about the extent to which we see one or the other of the following two mechanisms as dominant in promoting therapeutic change: (1) interpretation leading to insight, or (2) analysis of the present relationship per se and the corrective emotional implications of this relationship.

This group of essays also illustrates the extent to which the lack of specificity of the actual changes assumed to be produced by psychoanalytic therapy colors the discussion. An increase in general enjoyment of life, in internal freedom, and knowing "who one really is" are overall proposals that need to be translated into more specific aspects of an individual patient's life—his or her relationship to sex and intimacy, love life, relationship to work, friendships, relationships to creativity and to art and culture, and so on. In addition, of course, we would want to look at the degree to which the patient is freed from the symptoms that brought him or her to psychoanalysis in the first place. From the Lacanians' explicit rejection of concern about the therapeutic effects of the treatment, to Renik's emphasis on the concrete helpfulness that analytic work provides for a dominant problem in the patient's life, a broad spectrum of views has been represented here. More concrete, explicit statements about psychoanalytic goals and the related mechanisms of action of analysis are largely missing here. Nevertheless, these contributions are clear statements, thoughtful and explicit, about the particular technical approaches to patients that are proposed as leading to the therapeutic action of psychoanalysis (beyond the general controversy of the impact of interpretation in addition to or in contrast to the analytic relationship).

The most important technical approaches that emerge in these essays are the following: first, *transference analysis,* significantly stressed in the ego psychological approach and considered absolutely essential in Kleinian analysis (in contrast to its explicit neglect in "pure" Lacanian approaches—although not in the French mainstream derivatives of this).

Second, we find an emphasis on the *resolution of pathological defensive systems,* although the nature of these defenses varies in the different theoretical orientations. The resolution of pathological ego defenses, increased flexibility, and, shall we say, the sublimatory nature of ego mechanisms (leading to more adaptive compromise formations between defense and impulse) continue to be major objectives of contemporary ego psychological technique, while the modification of the primitive defensive system centering

around paranoid-schizoid and depressive defensive operations is a major concern of the Kleinian approach. Within this school, the shift from the predominance of the paranoid-schizoid position to the depressive one is a major therapeutic goal and a basic assumption regarding the therapeutic action of psychoanalysis, with particular stress, of course, on the resolution of paranoid-schizoid and depressive defenses in the transference.

Third, a *corrective emotional experience* is a major technical goal of the self psychological approach—specifically, completion of the relationship to mirroring and idealized selfobjects to an extent that is sufficient to facilitate transformation of the ego that has been pathologically fixated at an archaic level of development.

Fourth, the therapeutic implication of the *development of a new, specific relationship with the person of the analyst* emerges as at least one technical goal in the relational approach, usually in the context of an assumed interpretive approach to unconscious conflicts and to transference developments. Here, however, one needs to keep in mind the possibility that, if such a new relationship emerges as the consequence of transference analysis, it may constitute more an outcome than a technical approach. To the contrary, if a new reality experienced in the relationship with the analyst appears as a precondition for further analytic work, there are good reasons to suppose that this may occur at the cost of limiting the possibility of analyzing deep sexual and aggressive conflicts, and of neglecting the analysis of deeper aspects of the patient's personality in favor of the protection of a new and better relationship in reality than what the patient has been able to achieve before.

Fifth, a characteristic of the Lacanian approach, and significant also in the French mainstream, is the *direct interpretation of deep unconscious meanings,* bypassing the secondary process—in other words, the expectation that, while interpretations are directed in part to the patient's conscious ego, the most helpful ones also have a direct impact on the patient's dynamic unconscious, bringing about modification in the equilibrium of forces at that deep level.

* * * * * * * * *

This discussant believes it is fair to state that, in all these essays, the subject of employing different approaches with different levels of psychopathology is mentioned at various times, with corresponding modification of technique spelled out in this context, but this has not been approached in a systematic way here. What is missing is an elucidation of the nature of patients' psychopathology as linked to particular modifications of treatment—a framework for diagnostic analysis of patients applying for psychoanalysis in the context of indications and contraindications, and, let it be said, with the possibility in mind of utilizing alternative treatments derived from psychoanalysis that are not psychoanalysis proper, namely, psychoanalytic psychotherapy.

This subject comes up, indirectly, in Aisenstein's paper, in Hinshelwood's analysis of psychotic personalities, and, of course, in Newman's stress on the psychopathology of narcissism. It also comes up in Lander's overall classification of the psychopathology of patients as related to limits in the psychoanalytic cure. But the lack of a comprehensive, generally agreed upon system of classification of psychopathology—very often rationalized as the rejection of the rigid, superficial, descriptive approach of present-day psychiatry—is a missing element here.

Another missing element is the consideration of nonspecific effects of psychoanalytic treatment as contrasted to its specific effects. Within ego psychology, it used to be stated that the specific effect of psychoanalysis was structural intrapsychic change, that is, an increase of ego functions and a decrease of restrictions by superego-determined repression of instinctual needs. The concept of structural change has been gradually modified, such that it is now considered to be a significant change in the patient's character structure, and some empirical research has been developed around this concept. The Kleinian approach implies a concept of structural change in terms of the shift from a paranoid-schizoid to a depressive organization, and, within self psychology, the normalization of the pathological, archaic, grandiose self may be considered one criterion of structural intrapsychic change.

The enormous difficulty in translating these concepts into empirically testable hypotheses is a major challenge to the evaluation of the therapeutic action of psychoanalysis, although this discussant believes there is abundant evidence—on a clinical basis—that analysis may achieve significant characterological change that cannot be achieved by other psychotherapeutic modalities. In any case, all psychotherapies help, and some of the improvement derived from psychoanalysis may be shared by therapeutic factors in common with other therapies, and there is a need to sort out what is specific about psychoanalysis proper. This discussant suspects that, in the long run, the specific effects of interpretation will emerge as the most important contribution of psychoanalysis, in contrast to therapeutic factors common with other forms of treatment. This is still a hypothesis, although it may be reasonable to state that there are good clinical reasons for it, and even some preliminary empirical findings that support it.

To conclude, I now formulate more specifically my own view regarding the question, what helps? Interpretation leading to insight, or the analysis of the therapeutic relationship leading to a new type of object relation? I believe that systematic interpretation of the transference is the major factor of therapeutic action specific to psychoanalysis, and that the unique type of personal relationship achieved in the context of a technically neutral relationship, centered on the analysis of the transference, permits the building up of a new, unique type of object relation that gradually becomes an additional, important therapeutic function as a consequence of the systematic transference analysis. Obviously, such a systematic analysis of transference requires the analyst's persistent exploration of the transference-countertransference bond without losing touch, in the course of the merger into the dynamic unconscious, with the external reality. Formulated differently, the analysis of the object relation activated in the transference, the self and object representations and their respective affective investments, their projection and introjection, lead us into the patient's unconscious past at the same time that they lead into the reality aspects of patient–analyst interactions. The consistent analysis of the past overshadowing the present relationship is what is involved here.

REFERENCES

KERNBERG, O. F. (1993). Convergences and divergences in contemporary psychoanalytic technique. *Int. J. Psychoanal.,* 74:659-673.

——— (2001). Recent developments in the technical approaches of English-language psychoanalytic schools. *Psychoanal. Q.,* 70(3):519-547.

——— (2004). Rewards, dangers, findings, and attitudes in psychoanalytic research. *Canadian J. Psychoanal.,* 12(2):178-194.

——— (2006). The pressing need to increase research in and on psychoanalysis. *Int. J. Psychoanal.,* 87(4):919-926.

RENIK, O. (1999). Playing one's cards face up in analysis: an approach to the problem of self-disclosure. *Psychoanal. Q.,* 68:521-539.

---

*21 Bloomingdale Road*
*White Plains, NY 10605*

*e-mail: okernber@mail.med.cornell.edu*

*Psychoanalytic Quarterly, LXXVI, 2007*

# THE THEORY OF THERAPEUTIC ACTION

BY ROBERT MICHELS

## — I —

The notion of a theory of therapeutic action suggests a defined method of therapy that has an effect (presumably positive, at least most of the time) upon patients, along with a hypothesis about the mechanism that leads to that effect. This hypothesis can then be tested, validated, invalidated, or in the ideal situation partially validated, leading to suggestions about how to alter the therapy so as to enhance its therapeutic action. As these eight papers by leading figures in the field make clear, psychoanalysis is not yet there!

First, psychoanalysis is not a "defined method" of therapy, but rather a number of different therapies (perhaps more different today than in the past) that share a history, many concepts and ideas, many surface similarities, and a community of discourse. However, they do not share a uniformity of method, agreement on what is essential and what is peripheral, or a theory of therapeutic action. These papers emphasize how each author's ideas differ from the others', rather than the qualities they share, as though they were vying for dominance in the struggle to define the essence of psychoanalysis, rather than searching for a set of unifying concepts that will accommodate all. These authors discuss their theories of pathology and of technique, and largely seem to assume that their theories of technique describe putative mechanisms of therapeutic action. For the most part, they do not seem particularly interested

---

Robert Michels is Walsh McDermott University Professor of Medicine and Psychiatry at Cornell University, and a Training and Supervising Analyst at the Columbia University Center for Psychoanalytic Training and Research, New York.

in testing their hypotheses about mechanisms of action, and the only strategy for testing offered in these papers, most explicitly by Renik and Hinshelwood, is to observe the clinical outcome of the treatment.

However, there are at least two major methodologic problems with such a strategy, neither discussed fully. First, life is complex, and many factors influence our analysands apart from their analyses. (Hinshelwood recognizes this explicitly.) Most studies of the impact of therapeutic interventions adjust for this problem by pooling data from many individuals, hoping that factors other than the intervention being studied will be random and cancel each other out. Some studies also employ control groups that do not receive the intervention being studied. This allows the comparison of the natural course of life without psychoanalysis to the natural course of life plus psychoanalysis. Research analysts have discussed both of these techniques, but they are not mentioned here.

The second methodologic problem is that, in the course of studying the mechanism of action of therapeutic interventions, it is common to discover that the theory guiding the intervention has little to do with what actually makes a difference in its effect. For example, acutely agitated, disorganized patients are helped by a calm, concerned, related therapist who listens and tries to understand them without becoming disturbed by their affective outbursts. This is difficult for most therapists to do, and many are helped if they are guided by a theory that supports such behavior. However, the efficacy of the treatment that results has little to do with the validity of the theory that supports it. Systematic research on the mechanism of therapeutic action can clarify such issues, while clinical experience with individual cases cannot.

Psychoanalysts in general, and these eight in particular, do not discuss these solutions and do not comment on these problems. They seem unperturbed by them. One result is that, although psychoanalytic theories of therapeutic action have generated fascinating discussions of differences in theory and technique, they have seldom led to strategies for improving clinical practice.

Some have questioned whether the coexistence of several schools of contemporary psychoanalysis, each offering competing theories of technique and competing hypotheses concerning therapeutic action, is problematic. Why not embrace all of them? After all, as long as whatever is essential is included, what harm will come from admixing other presumably helpful therapeutic activities, whether or not they are "truly" part of the core of psychoanalysis? This approach has a potential problem, however. Many of the disputes among schools of contemporary psychoanalysis focus not only on what works, but also on how interventions suggested by various schools may not only be ineffective, but may actually interfere with the analysis. Indeed, one analyst's empathic containing is another's deviation from technical neutrality; one's optimal anonymity and frustration is another's intolerable narcissistic wounding; one's creative use of countertransference as a route to understanding an interaction is another's exploitive enactment of the analyst's personal agenda, and so on. A more precise understanding of which aspects of technique actually make a difference, and which are primarily symbols of membership in one or another school, might lead to a technique that is as flexible and comfortable as possible without interfering with the essential therapeutic components of the treatment.

— II —

These eight papers can be divided into four pairs of two each in terms of their views of the fundamental goals of psychoanalysis. The broadest formulation is Lander's. Echoing Bion, Lander rejects both symptomatic cure and adaptation in favor of helping the analysand "to be what he is," and, after Lacan, helping him "to insist in his desire" (Lander, p. 1500); the latter means that the analysand "accepts (without conflict or guilt feelings) the indelible marks of childhood that have resulted in the formation of his character" (p. 1511).

Aisenstein also rejects recovery from symptoms as a psychoanalytic goal. She speaks of the patient's coming to "appreciate the

value and meaning of his or her mental life," "the gradual understanding of and expansion of the psychic field" (p. 1455), and, after Lacan, that the analytic process is a goal in itself, with "cure" being only a byproduct. Psychoanalysis aims "at aiding our patients to become, or to become again, the principal agents in their own history and thought" (p. 1460).

At the other end of the spectrum, advocating relatively traditional, medical-like goals of cure of pathology, or at least improvement of some problem, are two of the North American authors, Abend and Renik. Abend wants to address "intrapsychic conflict of childhood origin" (p. 1435), and he quotes Freud in the goal of securing "the best possible psychological condition for the function of the ego" (p. 1422). He views Freud's followers as agreeing—for example, interpreting Strachey's theory of the introjection of the analyst's benign superego as "a pathway to transforming the anti-instinctual part of his or her psychic structure" (p. 1422)—in other words, as a technique with the goal of strengthening the patient's ego. The changing role of countertransference, as well as the interest in preoedipal development and in the patient–analyst relationship, are seen as coming under this rubric.

Renik hopes to alter the way in which his patients construct their experience so that they will feel more satisfaction and less distress. He sees the several current psychoanalytic theories—conflict, development, self psychology—as all having the same goal, but using different words to describe it. He asserts this similarity among them rather forcibly, but does not support it. I suspect that many advocates of these several theories would not agree.

Thus, Lander and Aisenstein want the analysand to be true to his or her authentic self, while Abend and Renik believe that something is wrong with the analysand and want to fix it. Spezzano and Newman are less concerned with goals in general, instead shifting the focus to what is required for the analytic process to work and the active role that the analyst plays in that process. Spezzano tells us that psychoanalysis is a special instance of the general case of minds acting on each other. In order for this to go well, "the patient's mind must feel at home in the mind of the analyst" (p.

1564), and facilitating this is at least a proximal or intermediate goal for the analyst. The next step, reminiscent of Renik's emphasis on co-construction, is for patient and analyst to play with the characters in the patient's inner mental world, rewriting their scripts, and redefining roles. The goal, again reminiscent of Renik, is to allow the patient to live a life that has less frequent, less intense, and less disturbing anxiety, less depression, shame, and guilt, and more frequent, more intense, and less disturbing excitement and pleasure.

Newman, interpreting Kohut, believes that many patients suffer from post-traumatic character syndromes that result from empathic failures of early caretakers. The goal of analysis is to offer a new opportunity for the patient to connect, and thereby to "reactivate derailed developmental processes" (p. 1514). Transference, for Newman, reveals the patient's "legitimate" needs, while he sees other analytic schools as viewing transference as disclosing "illegitimate" infantile wishes. (Once again, and perhaps in general, these papers seem weakest in characterizing the views of "other" schools, at times caricaturing them in order to highlight the positions being presented.) For Newman, the analyst is a new object, and if all goes well, becomes a "usable" one for the patient. The "analytic goal . . . [is] providing conditions suitable for achieving usability" (p. 1535).

Eizirik and Hinshelwood also emphasize the impact of the analyst on the analytic process, but, following Klein and Bion, their major emphasis is on the analyst as receiving something from the patient, transforming it, and then placing it back in the patient. Eizirik emphasizes the *analytic field,* in which the analyst listens to the patient's psychic reality and sees therapeutic action as residing in the "unique experience of being listened to and understood by another in a new way . . . which leads to the patient's acquiring a new understanding" (p. 1477).

Hinshelwood identifies two themes in our thinking about the mechanism of therapeutic change: the reorganization of the ego, and the "personal" aspects of the interaction, that is, ego psychology and Kleinian psychology. He traces the personal theme to

Klein's interest in play therapy with children, first as a substitute for free association, and then as the prototype of the enactment of transference-countertransference constellations. The Kleinian goal of therapy is "insight into the specific roles and relations exhibited and enacted in the transference" (p. 1483). The Kleinian equivalent of insight, Hinshelwood tells us, is when "the analyst's mind takes in a part of the patient or some part of the patient's experience, and modifies it by making it more tolerable," which, following Bion, he translates to more "intelligible" (p. 1491). This is then returned to the patient along with a part of the analyst's understanding mind. The patient's introjection of the analyst's mind enhances the patient's ego and heals pathological fractures in the patient's mental life.

## — III —

In the past, there was greater clarity about the method of psychoanalysis than about the goal. It was clear that insight was a defining characteristic of the method, although there was less agreement on insight into what—memories of early experiences, unconscious fantasies, memories of early fantasies, defensive adaptations to those memories and fantasies, resistances, transferences, or the dynamics of the evolving patient–analyst relationship. It rapidly became clear that that relationship was crucial—the patient's capacity to gain insight, indeed his or her very willingness to listen to the analyst, was dependent upon it, and insight into the relationship itself was one of the most powerful routes to insight into everything else.

Furthermore, the relationship had direct therapeutic impact, but that created a new problem. The therapeutic effect of the relationship was nonspecific—that is, it occurred in many other therapies, not only in psychoanalysis, and to some extent it even seemed anti-psychoanalytic, a concern that could hearken back to early discussions of "suggestion" and "transference cures." The way in which psychoanalysis combines insight and relationship, along with those ways in which it understands and employs that relationship that are

distinctive from its use in other psychotherapies, became central concerns of the theory of psychoanalytic technique.

Once again, the eight authors represented here span the spectrum of psychoanalytic views on the subject. Abend goes back to Freud; interpretations were "thought to provide the analysand with the necessary insight with which to effect changes" (p. 1420), while the relationship, although crucial, is "ancillary," providing a "background screen" for displaying the transference and motivating the patient to do the work. Although our understanding of the details has evolved, this basic scheme remains unchanged. Interestingly, the question of why insight should lead to change (and why, so often, it does not) is not addressed.

Aisenstein also views the relationship as relevant, but clearly secondary to the interpretive process. The analyst's interpretation may reveal "a hidden meaning" or may co-create "a previously absent meaning with the patient" (p. 1455), leading to an expansion of the psychic field. She follows Lacan and de M'Uzan in emphasizing that the most important impact of the interpretation is not that it "explains," but rather that it destabilizes, "with the element of surprise" (p. 1457).

Hinshelwood also sees insight as central, but he defines it quite differently. It involves the analysand's incorporation of the part of the analyst's mind that has metabolized and transformed the analysand's experience. Thus, the acquisition of insight, in a sense, is synonymous with the analysand–analyst relationship.

Eizirik also follows a Kleinian model, citing Segal's description of the "transference interpretation as the agent of therapeutic change" (p. 1465). He discusses the relationship context in which these interpretations occur and particularly emphasizes the importance of analytic listening, as well as the analyst's need to avoid the many biases and obstacles that can interfere with it. This listening is essential for formulating interpretations, but Eizirik goes further, suggesting that the listening relationship is itself therapeutic: "The therapeutic action of psychoanalysis rests in the unique experience of being listened to and understood by another in a new way" (p. 1477). Thus, along with Hinshelwood but in contrast to

Abend, Eizirik sees the relationship as more than the setting in which insight is acquired; it is an integral component of the uniquely psychoanalytic, therapeutic process of acquiring insight.

Lander sees two fundamental mechanisms in analysis, *insight* and *reliving*. He emphasizes that the critical mutative aspect of an interpretation is what the patient hears, not what the analyst says, and that the analyst's actions may have a greater interpretive effect than the analyst's words. His discussion of *reliving* draws on Winnicott's and Bion's thinking, but focuses on the affective experience of the analysand, rather than on the analyst–analysand relationship. He recognizes the importance of identification with the analyst as an essential step in facilitating the capacity of the analysand to achieve insight, but believes that this identification must be dissolved in order to terminate the analysis successfully.

Spezzano notes that "part of the [psychoanalytic] process involves the analyst's unconscious creation—out of sensation and affect—of metaphorical accounts of selves and objects playing out characters in the mind" (p. 1579). These characters inform part of what Spezzano feels he can contribute to the contents of the patient's mind. There is no suggestion that his preferred theories describe the "truth" about the patient, but only that the patient finds the process they facilitate helpful.

Renik emphasizes the relationship as the collaborative context for co-creation, rather than as the setting for discovery of preexisting fantasy or conflict, with the analyst's expertise residing in the skill to facilitate collaboration, not to observe or understand the patient's psychic life. Insight is defined, in effect, as a new co-construction that enhances the patient's life.

For Newman, the relationship is central. The patient suffers from a developmental disturbance, and the relationship with the analyst, when successful, provides a substitute for the earlier faulty relationship with the primary caretaker that led to the disturbance. Like Kohut, Newman believes that interpretations are valuable in increasing understanding and adding conviction, but, also like Kohut, he feels that this occurs as a secondary matter that is perhaps emphasized because it links self psychology with more traditional theories of psychoanalytic technique.

## — IV —

In summary, we have a lively and enthusiastic dialogue about therapeutic action in psychoanalysis. The participants in this collection articulate their views and develop them forcefully. A major problem for the field of psychoanalysis is that we have not yet developed a strategy or a language for comparing, testing, or evaluating these —for selecting from among them, for discarding some, or, more likely, selecting aspects of some and discarding others, developing creative combinations and evaluating the results. This is the challenge for the future.

---

*Department of Psychiatry*
*Weill Medical College of Cornell University*
*418 East 71st Street*
*New York, NY 10021*

*e-mail: rmichels@med.cornell.edu*

*Psychoanalytic Quarterly, LXXVI, 2007*

# IN SEARCH OF A THEORY OF THERAPEUTIC ACTION

BY HENRY F. SMITH

Once upon a time when analysts considered the mechanism of the therapeutic action of psychoanalysis, it was at a level of theoretical detail that has almost vanished from our discourse. While Freud did not discuss therapeutic action directly (as Aisenstein notes in this supplemental issue of *The Psychoanalytic Quarterly*), one can infer its mechanism at the most detailed level in his earliest theoretical model, derived from his study on aphasia and elaborated in his essay on "The Unconscious":

> The system *Ucs.* contains the thing-cathexes of the objects, the first and true object-cathexes; the system *Pcs.* comes about by this thing-presentation being hypercathected through being linked with the word-presentations corresponding to it. It is these hypercathexes, we may suppose, that bring about a higher psychical organization and make it possible for the primary process to be succeeded by the secondary process which is dominant in the *Pcs.* Now, too, we are in a position to state precisely what it is that repression denies to the rejected presentation in the transference neuroses: what it denies to the presentation is translation into words which shall remain attached to the object. A presentation which is not put into words, or a psychical act which is not hypercathected, remains thereafter in the *Ucs.* in a state of repression. [Freud 1915, pp. 201-202]

---

Henry F. Smith is the Editor of *The Psychoanalytic Quarterly* and a Training and Supervising Analyst at the Psychoanalytic Institute of New England, East.

According to this early model, the therapeutic action of psychoanalysis would consist in the lifting of repressions and the linking of thing presentations to word presentations. In fact, it may be that this is the only theory we have ever had that tries to explain what analysis actually does at this level of detail. While it does not tell us the function of action and interaction—aspects of analysis that were yet to be explored—it does give us a theory for why using verbal interpretations makes a difference. And there is no comparable explanation for the function of interpretation in any other psychoanalytic theory, including the structural model.

In the topographic model, to which the early writings on aphasia led, the therapeutic action of analysis lay in making the unconscious conscious. There are still parts of the world where analysts speak at this level of abstraction, although they use different words than Freud did. Bionians, for example, distinguish beta elements from alpha elements, and dwell on the development of alpha function so that alpha elements can replace beta elements. There is an analogy here to thing presentations and word presentations, although they are not comparable because the theoretical concepts behind the two systems are so different. Similarly, French analysts describe patients who do not have the capacity for representation, and they speak of waiting until the patient develops such a capacity before using interpretive measures, reserving that approach for verbal material that has become part of the symbolic discourse. Each of these approaches, however different they may be, depends on a topographic map of the mind. In this issue of the *Quarterly,* Aisenstein's work adheres most closely to the metapsychological view of therapeutic action, implied in Freud's (1915) work on "The Unconscious," with its topographic roots.

After Freud introduced the structural model, the discourse shifted somewhat. Rendering the unconscious conscious became *where id was, there shall ego be,* and, in Fenichel's terms, the therapeutic action of analysis lay in the alteration of the patient's defenses through the method of resistance analysis. On the other side of the Atlantic, Strachey spoke of therapeutic action in terms of modifications in the patient's superego, and famously focused on trans-

ference interpretations. Notice in this sequence that, starting with Fenichel, there is a subtle shift in what is meant by *therapeutic action* —a shift from the action of analysis to the method of analysis, from the modification of defenses, or of the superego, to the method of resistance analysis and transference interpretation.

Up to this point, however, whether we begin with the topographic theory or the structural one, we can still hear the original focus on what psychoanalysis does that effects change, but the trend toward method has increased more recently, so that for many of the authors in this issue, the question has shifted from "what is the action of analysis?" to "what is the action of the analyst?"—from what does analysis do, to what does the analyst do that is therapeutic? It is not analysis, then, that provides the therapeutic action, but the analyst. This coincides with a global shift in the interest of the field, especially in the United States, from the mechanism of analysis to the method—and even the person—of the analyst, and, more generally, from theory to practice.

Analysts in the past would have had no difficulty in distinguishing between a theory of therapeutic action and a theory of technique, the latter outlining what it is that helps and the former how it helps. But in this issue of the *Quarterly,* these distinctions become blurred as most of the authors make recommendations for what the analyst does or should do, as if the activities of the analyst defined therapeutic action. In such a process, therapeutic action becomes a synonym for technique. It is no coincidence that when therapeutic action was discussed in terms of the action of analysis, there was considerably less debate about technique. The fundamentals of technique were taken for granted; the mechanism of their therapeutic action was not.

Thus, over the years, the discussion has shifted to a different level of inquiry, without ever completely leaving behind the original understanding of what was meant. And this leads to a problem, one familiar to us all: each author in this volume tends to speak on a different level of abstraction—or on several levels at the same time, some explicit and others implied. Thus, between one author and another, there is a confusion of tongues, with the result that many of them seem to be talking past each other (Smith 2001).

Before considering the individual papers in more detail, let us summarize the different ways in which the authors in this issue understand the question that has been posed to them. For different analysts, the term *therapeutic action* means:

(1) *What does analysis do—that is, what is it doing to and in the patient?* This includes the recovery of memory, the lifting of repression, the granting of words to thing presentations, making the unconscious conscious, altering cathexes, modifying compromise formations, developing transmuting internalizations, modifying the superego, disrupting defenses, the accretion of structure, etc.

(2) *What does the analyst do?* This includes all the technical recommendations that the authors in this issue make along the way: the analyst analyzes resistance; *contains* (however this is defined) the patient, the patient's affects, or the patient's projections; listens to listening; interprets (however defined) different aspects of the patient's psychic life; provides insight; reviews the patient's expectations, etc.

(3) *What happens in analysis in the interaction between patient and analyst?* This includes the patient's identification with the analyst, with the analytic function, or with the analyst's signifiers; the projective-introjective exchange that takes place as analysts contain and modify parts of the patient; the provision of a selfobject function that has been missing from the patient's development; the establishment of a "real" or "authentic" relationship within which analyst and patient work collaboratively toward symptom relief, etc.

If all of these can be said to be part of a general consideration of therapeutic action, each of the authors in this issue can be situated on different levels of this schema, and can be seen as advancing different proposals within that level. Let us have a closer look.

Abend explicitly closes the loop between the theory of therapeutic action and the theory of technique when he notes that because "the theory of therapeutic action of any school of psychoanalytic thought is rarely stated , . . . therapeutic activity must be inferred from a study of the particular technical recommendations endorsed by a given approach to analytic practice" (pp. 1417-1418). This inference, however intriguing, draws on the historical trend toward conflating the theory of therapeutic action and the theory of technique. In Abend's case, this reflects a wish, I believe, to imagine a unitary theory in which theory of mind, pathogenesis, technique, and therapeutic action are all consistent with one another. In my view, this effort, while appealing, is premature and results in an artificially tight linkage between different levels of theory, on the one hand, and between theory and practice, on the other (Smith 2003a).

We also hear echoes of this wished-for linkage when Abend comments that, because the theory of therapeutic action is so rarely explicit, it must be derived "by implication from certain basic assumptions about what constitutes the structure of the problems in the analysand's psychology that analysis is supposed to address" (pp. 1417-1418). Here he would derive a theory of therapeutic action from a theory of mind or pathogenesis, a conflation that reappears when he notes that analysts in the 1950s "did not change the fundamental assumptions about pathogenesis, and *hence* about therapeutic action, that they had inherited" (p. 1424, italics added).

A theory of pathogenesis is not coterminous with a theory of therapeutic action, even by implication. Moreover, if we could evaluate precisely what in analysis is therapeutic and why, we might derive a technique to address it, but the two would nonetheless exist in separate domains. How the mind works, how analysis works, and what the analyst should do along the way might eventually coalesce into a common theory, but in the disparate state in which our current theories and practices find themselves, the argument that one can derive a theory of therapeutic action from an analyst's recommendations about practice seems fundamentally flawed. My impression is that the techniques of one analyst that prove useful fre-

quently have much in common with the techniques of another, even though the two analysts may hold different theories of mind; and successful interventions can often be justified after the fact from any number of different theoretical points of view. I should think that a determination of what is therapeutic in analysis might usefully begin with the study of what analysts do and the effects of what they do, leaving aside, for the moment, the theories of mind, pathogenesis, and technique that they adopt (often in retrospect) to explain what they do (or did).

Abend's useful review of the history of therapeutic action from within what he terms *modern conflict theory* makes clear the different levels of abstraction contained in the concept from even a single school. He begins with Freud's focus on the recovery of traumatic memories; along the way, he touches briefly on a period in the 1930s, highlighted by Fenichel and Anna Freud, in which "the theory of therapeutic action became crystallized as the systematic modification of the ego's capacity to deal with the persistent instinctual wishes of early childhood" (p. 1423); he then turns to the "new complexity" of the "role of the relationship between analyst and analysand as a prime determinant of therapeutic action" (p. 1428); and, finally, he situates himself in the conviction that "the traditional Freudian emphasis on the detection and interpretation of the derivatives of conflict, which facilitates the analysand's cumulative acquisition of insight into his or her nature and history, remains the most important tool for bringing about therapeutic results" (p. 1428).

Notice that the recovery of memory, the modification of the ego, the acquisition of insight, the detection and interpretation of the derivatives of conflict, and the relationship between analyst and analysand—all mentioned by Abend as different emphases in the evolution of modern conflict theory—are on different levels of abstraction. Gone, to be sure, is the effort to give words to thing presentations, or even to render the unconscious conscious (though the latter may be an implicit part of the acquisition of insight), which had their topographic referents.

But even within the categories that remain and have evolved in the structural theory, we are working within very different frames

of reference when we move among the following: from (a) the recovery of memory, which is something concrete that happens consciously to the patient, to (b) the modification of the ego, which is an explanation of something going on unconsciously at the level of one of the psychic agencies, to (c) the acquisition of insight, which is a general term to describe something that happens within the analysand, to (d) the interpretation of conflict, which is a technical tool on the part of the analyst, and, finally, to (e) the relationship between analyst and analysand—another general term to denote what transpires in the interaction of the analytic couple. It is not possible to compare all these elements with one another because they represent different levels of theory. It is, however, possible to consider that they may all be compatible within a single model, each at a different level of abstraction and describing therapeutic action at different degrees of specificity (Smith 2003b).

My focus on the mix of levels of abstraction is not just a theoretical or academic exercise; it is a clinical problem as well. Consider, for example, Newman's interpretation of a patient's dream. He tells us the following dream sequence:

> [The patient dreams that] . . . she has finished school but feels there are crucial courses she has missed; she is back at a school trying to find the right teacher to help her complete a particular course. The analyst interpreted that the patient sensed that certain psychological needs had never been fully met, hampering her in acquiring necessary emotional skills. [p. 1519]

While I have no quarrel with the interpretation that the analyst wants the patient to consider here, Newman takes the manifest elements of a dream, which exist on the level of clinical observation (Waelder 1962), and imagines that, through the window of the dream narrative, he can see the outlines of his own developmental theory, which is on an entirely different level of abstraction. It would be as if a conflict theorist could literally see the id and superego doing battle, or a Kleinian could identify the death instinct itself—not just implied, but concretely depicted in the images of a dream, ready to be pointed out to the patient.

In her own careful review of Freudian theory, Aisenstein suggests that the Freudian concept of working through captures the essence of therapeutic action. Despite what could prove to be a simple substitution of one vaguely defined concept for another, she then gives working through a specific metapsychological definition: it is the transformation of somatic energy into a psychic quality and the secondary growth of associative pathways. Returning here to the earliest Freudian model of thing presentations, she concludes her paper: "The cure proceeds from the transformation—by first passing through formal regression—of what is mute in the psyche into the phenomenon of language" (p. 1460).

Unique among the authors in this supplement, Aisenstein is content to use Freud's earliest and most specific terminology to describe therapeutic action. Moreover, more than any of the others, she concerns herself explicitly with the action of analysis, not the action of the analyst: "The therapeutic action of psychoanalysis is, in essence, a functional aspect of the psychoanalytic process" (p. 1447). Our one regret is that she is not more specific in her own views on this point. When, at the end of her paper, she notes that "therapeutic action must . . . be defined as the gradual understanding of and expansion of the psychic field" (p. 1455), we wonder if any analyst would disagree.

Aisenstein's reluctance to define more precisely what is therapeutic in the action of analysis is supported by a long French tradition of regarding the therapy of analysis as a byproduct and not a goal, a position she attributes primarily to Lacan, who argued that transference should not be interpreted because it would "lead the patient to identify with the analyst's self" (Aisenstein, p. 1456). Here, as well as in the contrast that Aisenstein outlines between Joseph's approach of interpreting what is happening between analyst and patient and de M'Uzan's view that such explanations only touch upon conscious elements and so lack "transformational impact" (p. 1457), we can see the current debate between French analysts and the contemporary British Kleinians. The latter, like North American analysts, are felt by the French to be too active and thus to neglect the deeper layers of the unconscious. We can also see in

this debate how much easier it is to compare views of analytic technique than it is to compare views of the action of analysis itself.

The opposite of Aisenstein's view of therapeutic action (and, by extension, of symptom relief) as a byproduct of analysis is Renik's position that they are the heart of the work. In contrast to Aisenstein's skepticism about the conscious elements of analytic technique, Renik develops his practice as a deliberately conscious, collaborative endeavor toward the explicit goal of relieving symptoms:

> Certain of the patient's expectations, assumptions, and decision-making can be reviewed and revised, as a result of which the patient's attitudes and behaviors change so as to afford the patient a feeling of greater well-being. Such, in my view, is the therapeutic action of clinical psychoanalysis. [pp. 1547-1548]

Here Renik focuses precisely on what Aisenstein does not: the analyst's technique in the consulting room. He does so because he sees the primary differences among analysts as "differences in *principles of technique*—which should follow closely from fundamentally different conceptions of therapeutic action, but which, in fact, often do not" (p. 1548, italics in original), a statement with which I completely agree. But, in my view, Renik has no grounds for prefacing this statement with the assertion that "the significant distinctions do not really concern the *essential nature* of therapeutic action as much as they concern the question of *how to bring about therapeutic action*" (p. 1548, italics in original). Different techniques may be compatible with a shared view of therapeutic action, but because analysts today tend not to specify what they consider to be "essential" in the action of analysis itself, we simply have no basis on which to conclude that there are no "significant distinctions" on this point.

Renik argues in favor of establishing a criterion "external to the treatment relationship and the clinical setting" (p. 1550) by which to judge the efficacy of an analyst's work. While it is true that the patient's experience of therapeutic benefit is an important piece

of data in assessing both the therapeutic action of any given analysis and its progress—one, I suggest, that needs to be analyzed like any other aspect of the work—given the intersubjective nature of the relationship that Renik has outlined, it is unclear to me what makes the patient any more "external to the treatment relationship and the clinical setting" than is the analyst. Surely, the essence of an intersubjective relationship is that both parties are mutually implicated in the clinical setting and the treatment relationship. If so, where is the "external" criterion?

More than any of the other writers in this issue, Newman draws on a particular developmental theory to underwrite the self psychologist's working model, focusing on the provision of a self-object container function that the patient lacks because of early parental failures. Along the way, Newman redefines resistance in analysis as a response to important genetic or empathic failures, developmental and analytic. His view of therapeutic action emphasizes the accretion of structure through optimal frustration, the engagement and removal of toxic affects, and the promotion of insight through transmuting internalizations that develop from repeated understandings of injuries suffered at the hands of the analyst. Most of his views on therapeutic action concern the nature of the relationship between analyst and patient. The concept of *structure*, however, appears to be formulated on the same theoretical level as that of ego structure in the "modification of the ego" that Abend describes. But there is no indication that Newman's concept of structure bears any resemblance to Abend's.

Among all the opinions included in this issue, Newman's position on therapeutic action is the most extensive challenge to traditional views. In redefining the basis for both resistance and psychic structure, for example, he takes familiar concepts and radically alters their meaning. This is a particularly effective rhetorical device, but it is such shifts as these in the meanings of concepts that make one analyst's view of therapeutic action very difficult to compare with another's, especially when the redefinitions are not as explicit as Newman's. There is a long history to the use of such rhetorical devices in self psychology, beginning with Kohut. Perhaps the most

vivid example is Kohut's oft-quoted metaphor of "the gleam in the mother's eye," the appreciative, loving gaze of the mother—or of the analyst—which has become a core feature of self psychological theory. Although its origin is never specified, Kohut's use of this phrase appears to be a desexualized revision of the old expression, "when you were just a gleam in your father's eye," with the erotic gleam in the father's eye replaced by the selfobject gleam in the mother's. On the level of theory, it is such shifts as these in the evolving use of psychoanalytic concepts that lead us to begin conversing on a common level, only to find ourselves speaking entirely different languages.

If we think back to the three ways of interpreting the question of therapeutic action—what does analysis do, what does the analyst do, and what happens in analysis between analyst and patient—we note that Spezzano makes an intriguing shift. Beginning in pursuit of what analysis does ("*Therapeutic action* has usually implied that psychoanalysis gets inside us and does something," p. 1563, italics in original), he proceeds in a kind of relational and Kleinian blend to break down therapeutic action into "the provision of a home for the mind of the patient," to which he adds

> . . . activities that might be described metaphorically as the mind of the patient unpacking itself—showing itself, being shown to itself by the analyst; finding abolished, dormant, undeveloped, repressed, and projected parts of a whole self; healing some damaged parts, taking in some new parts from the analyst. These activities are followed by the patient's leave taking, now that he or she is able to be a more emotionally alive presence in the world of other people. [p. 1571]

What is happening here? Starting in search of the action of analysis, Spezzano shifts not so much to the action of the analyst as to what happens to the patient in a successful analysis. It is a shift from the pursuit of the active function of analysis to a description of the results—-from what analysis does to what happens to the analysand. In this switch from active to passive, we have once again lost the thread of the action of analysis itself.

Of the other authors, I will mention briefly here (and discuss more fully below) Hinshelwood, who emphasizes the containing function of the analyst and, in a fashion similar to Newman's revision of resistance, redefines *insight* in terms of the principle of containment; Lander, who focuses on the role of language and action in the modification of the patient's superego; and Eizirik, who writes that the analyst's task is "to accept the pressure to do or to feel some particular thing, to reflect on the fact that he is being subjected to it, and then to make a limited and precise interpretation only about the immediate action" (p. 1466). As in this vivid description of the experience of formulating an interpretation, Eizirik's paper concentrates on what the analyst does.

I have suggested that, in addition to the fact that each of these authors discusses therapeutic action on a different level of abstraction (and often on several different levels at once), there is another difficulty in comparing their viewpoints. Each author uses familiar terms in idiosyncratic and sometimes undefined ways, so that while they appear to be speaking about the same concepts, they are not. I would like to illustrate this latter problem with a more detailed look at various uses of the terms *insight* and *containment*, two of the most popular expressions in our psychoanalytic vocabulary —and currently among the least well defined.

## INSIGHT

*Insight* is considered a core aspect of therapeutic action by almost all the authors represented here. But do any two of them mean precisely the same thing by it?

When Abend speaks of insight as a major factor in therapeutic action, he means insight into the nature of the patient's conflicts, and he sees it developing as the result of the interpretation of conflict:

> Insight may be generated by the analyst's interpretations, by the patient's self-discoveries, or both, but it is now widely agreed that this insight must be emotionally convincing to the patient, not merely intellectually apprehended. Ex-

> periences of the components of a patient's conflicts in the immediacy of the transference relationship are considered an essential part of the acquisition of truly meaningful insight. It should be noted that there are different assumptions about the precise content of the ideational components of these compromise formations within the mainstream psychoanalytic community, but these differences do not change the fundamental conception of conflict or the presumed therapeutic value of acquiring insight into its nature and origin. [pp. 1437-1438]

Despite the major differences in their views of pathogenesis, the path to its amelioration, and the analyst's most effective tools, Abend and Newman agree that insight is essential to therapeutic action, and they appear to agree on the target of the insight. Thus, Newman encourages "well-designed verbal interpretations that identify more accurately the nature of the unfolding transferences and the patient's psychological reactions to them. This will lead to deepening insight into the meaning of the current transferences and their genetic antecedents" (p. 1520). On closer examination, however, we find that Newman is not at all interested in insight into the nature of the patient's conflicts; he places more emphasis than Abend does on the genetic origins of transferences (by which Newman means the actual relationship with the parents); and he values insight that develops specifically as a result of "transmuting internalization[s]" (p. 1521).

For Hinshelwood, too, insight is at the core of therapeutic action, by which he means "insight into the specific roles and relations exhibited and enacted in the transference" (p. 1483). While this definition sounds as if it overlaps with both Abend's and Newman's views of insight, does it really do so?

There are surely significant differences between mainstream North American approaches to conflict and Kleinian ones, but these differences are compounded by what I take to be Hinshelwood's misreading of the former in his effort to contrast Kleinian technique with an ego psychological approach. Have a look at a passage in which he defines what he means by *insight.*

> From a Kleinian point of view, therapeutic change comes from a deeper understanding and insight into the specific roles and relations exhibited and enacted in the transference. That is to say, what is special about the third, therapeutic change spelled out at the beginning of this paper is the increase in insight. This contrasts with a theory that derives from Freud's interest in the structure of the ego. In the ego psychology approach, the aim is to influence the patient's ego to adopt new kinds of defenses and sublimations, and thus to strengthen it against the power of the instinctual id, which demands direct expression and satisfaction. Of course, insight may be used in the service of that end. However, the difference is this: one aim is the strengthening of the ego through better self-understanding, and the other aim is a strengthening of the ego through better organization of defenses. [pp. 1483-1484]

In this passage, it seems to me that words are used to divide us —even around the term *insight*, as if insight were not a central goal of work "that derives from Freud's interest in the structure of the ego." One cannot make this assertion without ignoring the ego psychological literature on insight, including work from the Anna Freud Center that addresses this very point (Kennedy 1979). Beyond this, however, there is little that Hinshelwood describes about the Kleinian point of view to which anyone, ego psychologist or otherwise, would take exception. Surely, we are all interested in "the specific roles and relations . . . enacted in the transference," as well as increasing insight and "strengthening of the ego through better self-understanding." It is difficult to know whom he has in mind when he speaks of the analyst who wants "to influence the patient's ego to adopt new kinds of defenses and sublimations." Is this his view of Anna Freud's teaching? Would any analyst today support it as a summation of his or her work? Even the notion of building a bulwark against the power of the instinctual id is a relic of a bygone era, as Abend's history makes clear to us.

Part of what confounds this passage is that—to return to an earlier point—when Hinshelwood compares *strengthening the ego through self-understanding* to *strengthening the ego through better*

*organization of the defenses,* he is comparing conceptualizations on different levels of abstraction: one at the level of everyday speech (self-understanding), and the other at a mechanistic level of analytic theory (organization of the defenses). Like entities measured in different units—the one in inches, the other in pounds, for example—the two cannot be compared, and this makes the entire argument suspect. These two conceptualizations may be compatible with one another or they may not be; we simply cannot tell from Hinshelwood's argument.

Putting it another way, pitting "self-understanding" against a "better organization of the defenses" would seem to result in a specious argument, since both might exist quite compatibly on their respective levels of abstraction. From a different point of view than Hinshelwood's, a shift in defenses might lead to greater self-understanding, or greater self-understanding might foster a shift in defenses. In either case, the concept of a reorganization of defenses can be seen as an attempt to describe what might underlie the development of self-understanding at the level of psychic structure.

Although he repeatedly notes that theoretical differences can be exaggerated, Hinshelwood continues to underscore distinctions on the matter of insight. In describing the ego psychological approach again, he writes: "Insight into the traumatic memory in the past allows the ego to reform in new ways that were prevented while the trauma was repressed. So much for the classical ego psychology approach" (p. 1484). Here he focuses—somewhat dismissively, it would seem—on an archaic, topographic model of the recovery of memory in order to dramatize the limitations of an ego psychological approach, which he contrasts with his interpretation of Strachey's view: "Insight, according to Strachey, is about the currently active phantasy, which builds the transference into a traumatizing experience now, with the analyst, in current sessions. Such insight could then assist the patient in instituting reality testing of his phantasies" (pp. 1484-1485). Is there any contemporary ego psychologist who would disagree with Strachey on this point?

Finally, Hinshelwood writes:

> A patient who sees the analyst as a castrating father will have the opportunity, as a result of insight, to see the analyst also as a helpful figure—which in reality the analyst probably is. Insight, therefore, has the effect of placing reality and phantasy beside each other. Interpretation aids the development of the reality principle, not the readjustment of the defensive structure. [p. 1485]

Until we get to the final phrase of this passage, we hear echoes of both Arlow and Greenson in the reality testing of the transference through insight (see the classic articles and commentaries in the January 2008 issue of *The Psychoanalytic Quarterly,* Volume 77, Number 1). Hinshelwood's very words spell out similarities where he intends to give us differences.

Having gone some distance in an attempt to establish these theoretical dichotomies, Hinshelwood then shifts the definition of insight dramatically in his discussion of *containment,* which he describes as

> . . . a foundation stone of the Kleinian theory of interpretation and treatment. The analyst's mind takes in a part of the patient or some part of the patient's experience, and modifies it by making it more tolerable. Bion made it clear that the modification occurs specifically to make the *something* intelligible; it is thus the Kleinian equivalent of insight. [p. 1491, italics in original]

Thus, after presenting insight as a core feature of therapeutic action focused on understanding the "roles and relations . . . enacted in the transference" (p. 1483), Hinshelwood ends by redefining it in terms of the processes of containment and modification (projection and reintrojection) that take place within the transference relationship. At this point, he seems to have achieved his goal: his definition of insight as the outcome of containment bears little resemblance to Abend's definition, or to Newman's, for that matter. In the end, all three value insight into the transference, but their views of just how that transference is understood and how it is approached—that is, what constitutes insight—vary considerably.

Whereas Hinshelwood's focus on containment has now landed us squarely in the joint realms of technique and the relationship between analyst and patient, Lander takes us back to the more specific question of what is happening in the patient, and to the action of analysis itself, with his focus on language and action. He begins his discussion of insight as a "mechanism of cure" in the following way:

> Insight refers to the capacity of the analysand to know what he has previously not known about, or has preferred to ignore, about himself. That is to say, something about himself is made conscious to the analysand that until then was not known or consciously acknowledged. In the process of analysis, this is achieved through the use of language. But sometimes, when words alone fail, it is achieved only through an act. [p. 1503]

Lander, like Hinshelwood, is interested in what facilitates the acquisition of insight, but, rather than containment, he focuses on identification. Furthermore, citing both Bion and Lacan, he emphasizes identification not with the analyst, but with the analytic function, and, more specifically, with the analyst's signifiers, which he then links to the Kleinian view of insight:

> The analysand will identify with certain signifiers coming from the analyst—for example, those signifiers seen as originating in the ideal analyst, which the analysand has come to understand through and from the analyst's interpretations. This will produce certain changes in the operation of the superego of the analysand. These changes in the superego will open the road to the acquisition of insight—or, at least, an increased capacity for the acquisition of insight—on the part of the analysand. This phenomenon closely resembles Kleinian (and other) analysts' conceptualizations of identification with the analytic function. [p. 1510]

Lander's definition of insight ranges widely from the more general process by which patients learn something that they had not known about themselves, facilitated by identification, to the very specific modification in the superego. But he is careful to keep

the levels of abstraction on which he discusses the term clear, so that they fit compatibly into his view of analytic process.

In focusing on the analyst's listening and interpretation of the here and now, Eizirik uses the term *insight* only once. In his view, insight develops from the experience of being understood. Thus, he concludes his paper with the following:

> I suggest that the therapeutic action of psychoanalysis rests in the unique experience of being listened to and understood by another in a new way, while present in what has been described as the psychoanalytic field, which leads to the patient's acquiring a new understanding of himself, thus reducing his psychic pain and becoming more free to enjoy his own capacities. This is the way through which insight might be obtained as a result of the experience of being understood in a new, fuller way than any previous experiences have provided. [p. 1477]

Here we see insight as a function of the analytic relationship.

Of the other three authors, Renik does not define precisely what he means by insight or how it comes about, but he applies the concept to his interest in practical benefit and empirical testing: "Valid insights are ones that produce enduring therapeutic benefit; useful analytic techniques are ones that produce valid insights" (p. 1551). Spezzano refers to insight only in passing, in characterizing the analyst as having "the privilege and role of being the one to whom seekers of insight and change direct themselves" (p. 1574). And Aisenstein does not use the term *insight* at all; indeed, unless she were to redefine it radically, her omission of the term is consistent with her point of view and her tradition, for as she comments, "the notion of 'understanding' at the level of secondary process seems less important in this [the French] model than elsewhere" (p. 1458).

My point here is that, while each of these authors would seem to value insight as a part of therapeutic action (with the possible exception of Aisenstein), what they mean by it, what it consists of within the patient, how the analyst brings it about, what the target of the insight is, and what is going on between the analyst and the

patient when it occurs are so vastly different in each case that a close examination seems only to highlight differences rather than common ground among the authors. What does it mean to have a conversation about the value of insight as a component in therapeutic action if no two people have the same concept in mind? How long would it take before realizing that, while we use the same word, we are talking past each other?

## CONTAINMENT

I want to turn now to another term, one that, following its initial introduction by Bion, has been used in increasingly varied ways; in recent years, it appears so frequently in clinical discussions as to have become a cliché, its meaning so broadened that it often bears little resemblance to the original term. The two authors in this supplement who highlight *containment* most prominently as a feature of therapeutic action are Hinshelwood and Newman.

Hinshelwood remains closest to Bion's original conception, which he quotes:

> The implicit aim of psycho-analysis to pursue the truth at no matter what cost is felt to be synonymous with a claim to a capacity for containing the discarded, split-off aspects of other personalities while retaining a balanced outlook. [Bion 1958, p. 145]

> When the patient strove to rid himself of fears of death which were felt to be too powerful for his personality to contain he split off his fears and put them into me, the idea apparently being that if they were allowed to repose there long enough they would undergo modification by my psyche and could then be safely introjected. [Bion 1959, p. 312; see Hinshelwood, pp. 1490-1491]

In reading these passages again, one cannot help wondering whether at this point in his career Bion imagined that the concept of containment would become the industry or "foundation stone" (as Hinshelwood puts it, p. 1491) of technique that it has in so

many parts of the world today. Bion seems in these early papers to use the phrase "too powerful to contain" in its everyday sense, as descriptive of what he was observing and experiencing in the work.

Be that as it may, in commenting on these passages, Hinshelwood first echoes Bion's clinical phenomenology: "This represents a process in which something of the patient is experienced by both parties as lodged in the analyst—at least temporarily—for a process of modification, before being returned to the patient" (Hinshelwood, p. 1491). But then his tone becomes more pedagogical: "This particular modifying process is termed *containing*" (p. 1491, italics in original). This shift in tone reflects the fact that a once experiential, informal term has now been reified as a technical and mechanistic tool, as seems to be the fate of many such terms in psychoanalysis that started out as simple observations.

As discussed above, Hinshelwood goes to some lengths to differentiate Kleinian approaches to therapeutic action from ego psychological ones. And this is no less true of his discussion of containment. In elaborating on the passages from Bion, for example, he observes that "what *containing* refers to, then, is not so much the resolving of an intolerable conflict as the *repair of a mind*" (p. 1492, italics in original). While the words *containing* and *repair* belong to the province of Kleinian clinical thinking, I wonder if the dichotomy Hinshelwood poses here is once again more apparent than real—a matter, in other words, of using words to build fences between groups. If we do not force one set of words into collision with another, from the point of view of clinical experience, might not "resolving an intolerable conflict" and "repair of a mind" amount to the same thing?

Hinshelwood continues:

> Increasing interest in Kleinian therapy represents a steady move from understanding conflict to understanding the way in which a mind fails to function and can disband itself. The analyst's process of containing is the performance of an ancillary function for the patient. He helps to put a mind together again so that it can subsequently begin to contain itself and its conflicts. [p. 1492]

And, finally and most importantly: "Therapeutic action is thus the enhancement of the ego in its ability to contain its experience and tolerate its conflicts" (p. 1493).

Here again, I have no quarrel with what Hinshelwood is saying. I value his technical clarity, agree with much of it, and appreciate his words as descriptors of the experience of analyzing. But it is not clear to me that the work he intends to designate by these abstractions is necessarily so different from the work he intends to exclude. If we substitute the word *person* for *ego*, for example, would anyone, Kleinian or otherwise, disagree with the statement that "therapeutic action is thus the enhancement of the [person's] ability to contain [his] experience and tolerate [his] conflicts"? I should think that any conflict-based analyst would consider this an integral part of "understanding" those conflicts. Once again, Hinshelwood's words speak of differences but suggest compatibilities.

The concept of containment plays a prominent role in Newman's view of therapeutic action as well, but here it has an entirely different, self psychological emphasis. In brief, rather than speaking of the patient's or the analyst's capacity to contain split-off bits of the patient's internal world, Newman's developmental interest is in the actual parent's (or the analyst's) selfobject role in containing and regulating the patient's affects.

He also emphasizes the containment of the analyst's "subjectivity," a task that sounds at first to be related to a Bionian view of containment, if expressed in very different language, but turns out to be part of a dialogue with those relational and interpersonal psychoanalysts who advocate that "using their subjectivity brings authenticity to the work." Newman counters:

> Self psychologists . . . have answered this critique by stressing that many patients require an empathic milieu in which the analyst contains his subjectivity. In stressing that the locus of pathognomonic fixation is at a time of the formation of the self, when the self has been so traumatized as to disrupt its further development, the rationale for containment of the analyst's subjectivity until a time in treatment that a core self has been more firmly established seems cogent. [p. 1524]

Acknowledging that he has adapted Bion's view of containment to a self psychological model, Newman writes:

> Winnicott . . . , with the notion of holding, and Bion . . . , with the concept of a container function, addressed the activities required of what we would now refer to as the good enough selfobject, managing rising tension states and communicating paradigms of calming. [pp. 1536-1537]

The self psychological emphasis on the actual containing of the patient and the patient's affective states, like the containment of the child's affects (which is not part of Bionian containment), is clear in the following passage:

> While many self theorists (Wolf, Siegel, and others) have highlighted the repair/disruption sequence as vital to the ongoing therapeutic process, the emphasis on the analyst as the provider of a specific container function is more often an implicit one. If the analyst can successfully help the patient manage the turbulence of intense and often hostile feelings, this may serve as a paradigm for a new relationship to the self, and, internally, to the patient's selfobject, in regard to affects. [Newman, pp. 1533-1534]

In fact, however, it is Kohut who Newman feels neglected the point he would like to stress. Accordingly, Newman makes it his goal in this paper to convert self psychology's "implicit" emphasis on the containment of affects to an explicit part of therapeutic action: "While Kohut always recognized the crucial importance of early selfobjects for their soothing and self-regulating functions, the centrality of affects—or the need to contain unmanageable feeling states motivating defensive restitutive character formation—seems to have been minimized" (p. 1536).

Thus, Newman introduces a fundamental change in the concept of containment as a developmental and interpersonal phenomenon: "The patient requires a selfobject to help regulate unmanageable affect states" (p. 1521). And his conclusion prominently features the role of containment:

> The recognition that complex defensive organizations are designed not only to protect against retraumatization, but also to contain unintegrated affect, illuminates the role that selfobjects play in providing a holding function. In view of the fact that many of our patients present with pathology that reflects a failure in the selfobject-as-container-function, it follows that this dimension of need should emerge as a forward-edge transference in its own right. [p. 1544]

Both Hinshelwood and Newman argue that containment is essential to the analyst's role, but they seem to be using the same word to describe different activities at different levels of psychic life. For Newman, it is the direct containment of the patient and the patient's affects, a soothing or holding (selfobject) function; for Hinshelwood, it is the containment in the analyst's mind of split-off affects and discarded aspects of the patient's mind. In practice, could the analytic functions they describe turn out to be similar despite the authors' divergent theories? Newman seems to think so, given his comment that Bion "addressed the activities required of what we would now refer to as the good enough selfobject." It remains impossible to know, however, without comparing details of their clinical work.

Of the other authors, Eizirik illustrates Bion's container/contained formulation through a discussion of Joseph's clinical approach, but his own use of the term *containment* seems to have less to do with the patient's affects than with the analyst's: "Continuous analytic work along these lines shows the analyst how to accept therapeutic limitations by learning to contain and to use constructively his feelings of therapeutic discouragement" (p. 1466). Such feelings of discouragement would presumably be projective identifications derived from the patient, but the feelings might originate in the analyst; Eizirik does not say. We have here again a broader application of the term *containment*, one that, however useful, lacks the specificity of Bion's original formulation.

It is important to note in passing that, while Aisenstein does not use the term *containment* in her paper, she introduces a view

of interpretation that bears some resemblance to it, albeit expressed in terms that owe more to Freud than to Bion:

> The work of interpretation . . . consists in a painful process of binding (Freud's *Bindung*) and unbinding elements—what I call *microtrauma*—from a field of thought co-generated with the patient. By *co-generated*, I mean that, in the context of the frame of the session, the patient's psychic working through is sustained, completed, and revived by the preconscious of the analyst. [p. 1454, italics in original]

This is further evidence to support the hypothesis that, if we could examine clinical work more closely, we might find a convergence of clinical approaches despite the disparate theoretical positions that analysts use to explain them (Smith 2005).

Finally, Spezzano takes a leap in the ongoing transformation of the concept of containment in his paper, "A Home for the Mind," in which he gives the term a much broader reach:

> To experience oneself as symbolically having a place within the fundamental meaning system of the universe is to be protected against the threat of chaos—to be *contained,* as we might now say. [p. 1566]

> The mind of the patient searches for a home in the collective human psyche, and more immediately in the mind of the analyst. [p. 1569]

Spezzano explicitly wants to distinguish his use of the term from a more traditional view of containing projections:

> I will try to distinguish the issue I focus on in this paper from the issue of the analyst's ability to contain anxieties projected by the patient or to create a safe space for the patient. I am specifically raising the need for the patient to experience the analyst's mind as a place within which the patient exists as an internal object—an internal object toward whom the analyst relates with agency and freedom. [pp. 1563-1564]

Despite Spezzano's objections, we hear distinct echoes of a Kleinian focus on the patient's experience of having a place (as an "internal object") in the analyst's mind. But Spezzano's view of the traditional definition of containment, against which he wishes to have his view compared, is not so clear. Where, in fact, is Bion? What has happened to the projection of split-off parts of the patient's mind?

The issue gets further confused when Spezzano adds a more extensive perspective on the analyst's activities in a summary of his view of therapeutic action:

> This metaphorical ideational and emotional muscle memory allows the analyst to do the following: to listen carefully, see things that would escape the attention of others, point to and interpret what is observed, contain bad feelings, tolerate being a bad object in someone's mind, make connections between things that are in the patient's mind so that new realizations can take place, and make all the other moves that have been reported as helpful in one case or another—as well as to live with the sudden realization of having made an error and with the constant awareness of never being able to see all the possibilities. [p. 1572]

Notice here that he includes the containing of bad feelings and the tolerance of being a bad object, despite arguing that he is *not* speaking of "the analyst's ability to contain anxieties projected by the patient." And so it would seem that he wants us to hear his use of the concept of containment not only in a new way, but in the old way as well.

If it is truly the fate of all psychoanalytic concepts to broaden over time, these brief looks at the concept of containment would suggest that the process is far more complex than a simple expansion. In the various versions of containment discussed above, we can observe a circular process in which something that Bion once meant as a specific term to describe his clinical experience of the patient (and the patient's experience of him) becomes mechanized and reified as a therapeutic tool, thus granting it an extra mea-

sure of legitimacy. Subsequently, as the term falls into more general use, it is broadened to the point that it seems to lose touch with its earlier, specifically descriptive value. And yet, in these broader uses, there is an attempt to retain the legitimacy granted both by its original usage and by its subsequent mechanization and reification. Thus, *containment* continues to be applied in ways that are vastly different from Bion's original intent, but we hear them as if they had all the validity of the original formulation. It is a problematic and at times malignant process.

It is often said—as Abend summarizes in his paper—that on the matter of therapeutic action, analysts split into two groups: those who believe in the value of insight and interpretation, and those who believe in the value of the analytic relationship. On the face of it, this brief survey of various points of view would seem to support the simplicity of this distinction. Standing at a great distance, one can imagine dividing these authors into two such groups, with the Insight and Interpretation Team on one side and the Relationship Team on the other. Moving a bit closer, however, we see another truism coming into focus, for the authors seem to arrange themselves on a spectrum stretching from the more insight-oriented group, represented by Abend and Aisenstein, to a more relationship-oriented one, represented from their respective theoretical positions by Spezzano and Newman, with every author illustrating an idiosyncratic blending of the two. But in examining two terms that we might think of as representative of each group—*insight,* on the one hand, and *containment,* on the other—we find such sharp disagreement about what is meant by each, how it is derived and how used, that at this level of observation, we seem to have only differences to examine, not similarities. The result, once again, is a confusion of tongues.

Beginning with a look at the evolution of what analysts have meant by *therapeutic action* over time and the disparate levels at which they have addressed it, I have tried to illustrate some of the complexities of comparing and contrasting different views of this concept. As we have discovered, it is not simply the different levels of abstraction that confound our discourse and force us to talk

past each other, but it is also the fact that, on the matter of key concepts like *insight* and *containment*, we have little agreement about meanings. Perhaps, if we could study each analyst's clinical work without access to the theories that purportedly lie behind it, we would begin to find similarities amongst apparent differences—and differences amongst apparent similarities. Then we might see a realignment of traditional "school ties" and a consequent reconsideration of theory. Out of this process might also come hypotheses about therapeutic action based on the observation of what analysts actually do and how their patients respond to what they do. But that remains for another project.

## REFERENCES


Bion, W. R. (1958). On arrogance. *Int. J. Psychoanal.,* 39:144-146.

——— (1959). Attacks on linking. *Int. J. Psychoanal.,* 40:308-315.

Freud, S. (1915). The unconscious. *S. E.,* 14.

Kennedy, H. (1979). The role of insight in child analysis: a developmental viewpoint. *J. Amer. Psychoanal. Assn.,* 27:9-28.

Smith, H. F. (2001). Obstacles to integration: another look at why we talk past each other. *Psychoanal. Psychol.,* 18:485-514.

——— (2003a). Theory and practice: intimate partnership or false connection? *Psychoanal. Q.,* 72:1-12.

——— (2003b). Conceptions of conflict in psychoanalytic theory and practice. *Psychoanal. Q.,* 72:49-96.

——— (2005). Dialogues on conflict: toward an integration of methods. *Psychoanal. Q.,* 74:327-363.

Waelder, R. (1962). Psychoanalysis, scientific method, and philosophy. *J. Amer. Psychoanal. Assn.,* 10:617-637.


---


*17 Hammond Street*
*Cambridge, MA 02138-1915*

*e-mail: henryfsmith@gmail.com*