Volume LXXXIII, Number 4

BECOMING RELATED: THE EDUCATION OF A PSYCHOANALYST

BY STEPHEN D. PURCELL

The author uses a "professional memoir," a story about his first experiences in clinical work, to illustrate what he believes to be certain fundamental aspects of an analytic attitude. Taking place in a psychiatric hospital, it is meant to highlight the central place of intuition, emotional receptivity, empathy, relatedness—and their inherent dangers—in engaging therapeutically with patients' emotional disturbances. The author postulates that these and related aspects of clinical psychoanalysis are not sufficiently emphasized in psychoanalytic training and are often eclipsed by idealizations of psychoanalytic theories and their derivative techniques, third-party demands for evidence-based data, preoccupations with neurobiological correlates of experience, etc. Despite the clinical fact that psychoanalysis can be extraordinarily helpful to patients, he questions whether clinical psychoanalysis is rightly regarded as a "treatment."

Keywords: Psychoanalytic training, analytic attitude, intuition, therapeutic relationship, seriously disturbed patients, emotional engagement, group dynamics, analytic technique, transference.

SYBIL

Heading up the tree-lined approach, I got my first view of it. The two-story, yellow brick building was fronted by a circular drive and ten large,

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Stephen D. Purcell is a Training and Supervising Analyst at San Francisco Center for Psychoanalysis and a Personal and Supervising Analyst at the Psychoanalytic Institute of Northern California.

curtained windows across each level. In the humid stillness and the blinding sun, it sat, silent, on a slight rise in the earth, foreboding and fortress-like, surrounded by a moat of asphalt. There was absolutely no sign of life, which in those initial moments was oddly comforting.

At first, I had been relieved to hear that the hospital was hiring "psych techs." Not that I was thinking about psychiatry, but I needed something to occupy me for the summer. At twenty-one, I thought the job sounded intriguing, even exotic; and it might offer respite from my mounting sense of aimlessness.

Arriving now for an interview, I was very nervous. Charged by eruptions of doubt about whether I could do this, my mind spun up disturbing, half-formed images of what awaited me inside. I was expecting the horrors of the Bedlam. And while the unlikely tranquility of the setting suggested a possibility of palliation, the inanimate monolith also hinted at something suppressive that, in 1968, was inextricably bound up with psychiatry.

As I tentatively pushed open the door and cautiously moved into the plush, quiet lobby of this alien place, a welcome rush of too-cold air collided with the Georgia heat on my face. That familiar sensation drew me down, grounding me back in the known world.

I had not expected my interviewer to be a nurse. A tall, angular woman, Sybil wore a white nurse's dress and cap and exuded a cool professionalism in the performance of her role, inscribed on a name tag as "Head Nurse." At first, she made me think of a bird as she looked at me intently from behind thick glasses, tilted her head slightly to the side, squinted her eyes, and scrunched up her nose, examining me with obvious skepticism. She seemed preoccupied, thoughtful about something else; but she was also smooth and efficient in the execution of her task.

As we talked, Sybil conveyed an unusual mixture of directness and remove, perhaps self-possession; and I found myself paying close attention. She was clearly quite present but without transparency. She asked a few simple questions about my background, explained the job (mainly I was to form "therapeutic relationships" with patients), and, sooner than I had expected, hired me for the summer. Momentarily pleased to be employed, I was then pitched back into riding out my fear about what I would find when she took me behind the locked doors to see "the ward."

I had no inkling of how to be in there and my imagination could not conjure what I was ignorant of, what I would need to know.

My job began with a week of orientation—working nights with Sybil. There were forty psychiatric patients and the two of us on the graveyard shift, alone in the dimly lit building, locked up tight. At regular intervals, one of us shone a flashlight into each dark room to see how things were. Sybil seemed curious to find out; I was calmed by finding things in order. For most of the long, quiet night, we sat together, enclosed behind Plexiglas walls (the "nurses' station") in one corner of the main living room.

We drank coffee and talked about our charges—their diagnoses, histories, family situations, and treatments. Sybil seemed to know many of them very well; and I noted how she spoke about these "mental patients" with a warmth and familiarity that in my life had been reserved for close *personal* relationships. She went over routine procedures and rules of the ward, taught me how to measure and record blood pressure, and implored me to accept the obvious but apparently elusive fact that "you can't talk reason to unreasonable people." Clearly, she had a good sense of the pitfalls for a novice like me.

Sybil explained that, occasionally, patients would lose control of themselves and need us to take over; so she instructed me in techniques of subduing those who became violent and of safely restraining them in the "seclusion room." But, mainly, she emphasized in her plain-spoken way that these people were suffering, that many were emotionally and interpersonally isolated, and that they needed someone to listen and to show understanding. Sybil taught me with questions about the details of what I noticed, with critiques of what I said to patients, and with encouragement to watch her ways of interacting with them. Slowly, she seemed to accept me, and I enjoyed her more lively and casual way of being with me.

My fourth night on the job, the early morning stillness was shattered when a new admission suddenly burst from his room and careened into the area just outside the nurses' station. A large man, sweating profusely, disheveled and wild-eyed, lurched in our direction, picked up a table lamp, and slammed it against his reflection in the thick glass of a window. He looked terrified, as if anticipating attack. Through the inner roar of

my own terror, I managed to hear Sybil say, "Mac's going into DTs. You stay here, but watch and come if I need help."

Respectful of the man's gravely altered state and with genuine equanimity belying the very real danger for all of us, Sybil cautiously approached this frightening figure. I watched her speak calmly to him for a few minutes before she gingerly placed her arm beneath his and guided him back to his bed. That was when I first noticed her courage.

From my protected position behind the transparent walls of the nurses' station, I could not make out what Sybil said to Mac; and I could not imagine the words that had wielded such power. There was a lot I did not understand; yet I sensed that I had just been privy to something quite remarkable and, as I realized later on, very rare. While eventually in my work as a physician I would witness many people withdraw from alcohol addiction, only occasionally did I see a caretaker offer verbal tranquilization to a person in DTs. I never again saw anyone do it successfully.

So, grounded in the basics of the job, I moved to my regular staff position. Gradually, I became aware that Sybil began her time on the ward each day in the exact same way. Radiating energy and fueled by some self-generated sense of purpose, she would breeze into the crowded nurses' station, where the departing and arriving nurses and psych techs were all gathering for "report," chirp an evanescent "hello" at no one as she put down her purse, and right away walk briskly around the entire ward, poking her head into patients' rooms, greeting by name and conversing briefly with each person she encountered.

Sybil called these excursions "making my rounds," and at first I believed she used some sort of checklist to guide her inspection, carefully scrutinizing everyone in order to arrive at empirical conclusions about each patient's condition. Only later did I understand that she was not fact-finding in any ordinary way; she was deriving her assessments not only from what could be seen, heard, and thought about with objectivity, but also from something felt, not perceived directly. As she roamed the hallways with emotional antennae fully extended, she picked up and processed crucial information, using her unique combination of discerning observation and unfailing intuition.

In the few minutes that it took Sybil to circle the ward, she developed what appeared to be consciously unreasoned—yet consistently insightful and useful—impressions of forty individual minds and of the psyche of the group. She would know instinctively, it seemed, if any individual or the group itself might be especially vulnerable, impulsive, or needful of attention or protection; and she would instruct staff members to intervene in specific ways on this basis: "Go sit with John; see if he can tell you what is bothering him," or "Try to get Sheila out of her room and into the group."

Eventually, it was clear to me that behind Sybil's professionalism and sometimes stolid exterior there was a vibrant presence, one combining implicit understanding with laser-like attention and rare emotional sensitivity. Her routine competence was thoroughly imbued with these qualities. I had never known anyone like her.

Despite the dominant position of psychoanalysis as the preeminent paradigm within psychiatry, Sybil professed little academic knowledge of psychoanalytic theory. Coming from the foothills of the Blue Ridge Mountains, she had the common sense befitting someone raised in the "Chicken Capital of the World." She did not lean on abstractions to tell her what made people dysfunctional or how to help them relate and cope; she claimed to have learned on the job in a state hospital. But however it happened, she had so honed her abilities to empathize with and relate to emotional disturbance that, to everyone who witnessed her *be* with patients, being therapeutic appeared to be her natural mode. It was the way she *was*. And when she *was* this way with patients, it allowed them to engage safely with her and with their own threatening emotional experiences. Almost universally, they revered her for the help she provided. Though quite capable of softness, Sybil was never sentimental with her sensitivity; and, bit by bit, I saw her personal strength and clarity of purpose revealed in her work.

At that time, hospital personnel were not sensitized to omnipresent threats of legal action. Even so, most staff were intimidated by one particular patient, an especially cold and litigious person who had fired, threatened, and sued a number of her former psychiatrists. Cheryl was an extremely angry and vituperative middle-aged woman, hard to help, and prone to explosions of destructive and self-destructive impulse. Ex-

cept for her current psychiatrist and Sybil, who had worked diligently to establish their personal connection, there was no one in the hospital community with whom she would converse. With Sybil, she usually seemed comfortable, respectful, and often quite friendly. After spending a few months in the hospital, the patient was able, at last, to tolerate a secretary's job on the outside, returning to her hospital home at night and on weekends.

Cheryl occasionally took meals in her room, which she did one evening after returning from work, upset by some conflict there. After dinner, Sybil asked, as a precaution, that I accompany her to check on Cheryl. She knocked on the door and entered, while I remained just outside in the hallway. Holding a glass of iced tea as she approached the patient, who also had her own drink in hand, the kind nurse warmly greeted this remote and sullen woman. In response, Cheryl abruptly launched an inexplicable angry tirade and without warning emptied the contents of her large glass into Sybil's face. Frantically, I wondered what to do, while Sybil silently took off her glasses and wiped them on her sleeve. Putting her glasses back on, she calmly and quizzically looked Cheryl in the eyes and then with a fluid motion tossed her own beverage directly back into Cheryl's face.

The hostile patient and I were stunned. At first it seemed that Sybil had fallen into a serious, perhaps irreparable lapse in her usual good judgment. Wide-eyed and angry, Cheryl squared off and stared ambiguously at her for a long moment. Then, as if on cue, the two women simultaneously broke into deep laughter as they affectionately embraced one another. I was incredulous at this unimaginable turn of events: as real as Cheryl's aggression had been, it was replaced, almost magically it seemed, with something that felt even more substantial. Sybil's action appeared to provide the same calming effect I had seen her words bestow on Mac.

It was hard to think through the emotional complexity that underlay this manifestly simple yet powerfully affecting interaction. Watching the scene unfold, I sensed the humiliation Cheryl intended and the shock and outrage Sybil had to manage. But clearly, Sybil had not sought retribution. Although what she did was in direct opposition to the prevailing norms of professional behavior, as well as to the relational limits fixed

rigidly in place by Cheryl, somehow she had been exactly emotionally accurate in her response. The unexpected result was a realization of the therapeutic potential embodied in Sybil's way of relating.

I felt certain that most people would have reacted to what was so obvious and urgent—Cheryl's hostility. But Sybil had not. She must have known that Cheryl was doing more than simply spewing anger. Looking back, it is apparent that Sybil engaged in an emotional dimension more nuanced and foundational: Cheryl was biting the hand that fed her, attempting to ruin the best thing she had. It was this pressing paradoxical need to attack the goodness in the relationship that was central to grasping the meaning of her destructive behavior. Using a language of action in which Cheryl was fluent, Sybil stood up to the attack, protectively neutralizing the implicit self-destruction and the hostility while preserving and reconnecting Cheryl with the goodness she had wanted to spoil. Sybil's response was no error in judgment; it was brilliant intuition, incisively employed. It was a perfect moment.

Sybil had impressed on me the value of understanding, but had told me little about how to give it. What I could see that evening was that the empathy informing Sybil's action required exceptionally close contact with and acceptance of Cheryl's deeper, disavowed feelings; and it provided the patient with a vivid experience of being understood. Sybil drew on her unusual emotional equanimity and her ability to think beneath the surface and *into* emotion to show Cheryl the destructive and dehumanizing function of her aggression in an immediate and plainly personal way. No one else in Cheryl's world could have done what Sybil did and gotten away with it. But it was obviously not *what* Sybil did; it was the way she *was* in doing it that allowed Cheryl to recover the warmth and affection so crucial, so valuable, yet at the same time so threatening to her.

So much for the psychiatric suppression of mental patients.

TOMMY

The job required some adjustment. Even though Sybil had warned me that I might feel as though I were not working hard enough, it proved very difficult to accept the premise that a big part of what I was to do was

to form relationships with my patients. At one level, it seemed too easy, but at another, the complexity of my task felt enormous.

The ward operated on a model of "milieu therapy," according to which the hospital social system was to be a container for and modifier of the psychologies of the individual patients. An important part of the structure of the hospital community was the relationships provided by the staff; they were a key part of therapy and were meant to provide safe opportunities for emotional engagement and to be sources of feedback, both direct and implicit. There was permission but also an obligation to be truthfully "myself" in these relationships . . . as long as being so was good for the patient.

But what was good for the patient? I really did not know, and I was afraid that in my ignorance I would hurt someone. It was not that I felt particularly injurious; but I knew, beyond doubt, that I lacked any sophisticated appreciation of the delicate intricacies of emotional problems. Was it not true, after all, that these people—those with whom I was to have relationships—were psychiatric patients because of actual emotional frailties? Were they not psychically ill in some way to the point of needing the around-the-clock protection and intensive treatment of a hospital? Did these things not imply fragility?

To complicate matters further, many of these people did not seem so abnormal, so different from me. Some were understandably depressed or anxious in response to their stressful life situations, while others were chronically unhappy and self-destructive because of their inner stresses, their problematic personalities. There were also teenagers who had taken their experimentation with drugs too far, who were part of the large group of '60s runaways, or who had otherwise come into conflict with the law. In many respects, these people were too easy to identify with, too hard to differentiate from me. Tentatively, I thought that this hospital was not the Bedlam after all.

So how was I to behave with a patient who seemed like me but was supposedly somehow not like me? What would help? What did it mean to be careful with these people? I worried about these things.

"Sympathy isn't enough. Be curious," Sybil said. "Ask questions and stop if they get too uncomfortable." She tried to be simple with her direction, ultimately rooted in her belief that, with my heart in the right

place, I would do no serious damage. I thought that might be true, but I could not feel sure of it. I had too little real experience in support of that perspective, and I was not reassured. It seemed as though an impending disaster was lurking close by, in psychic territory that felt very alien. I see now that, simply put, I was too green, too unseasoned by life to have clarity about what I had to offer or to feel confident about the plasticity and resilience of others.

Tommy was the first patient assigned to me. At fifteen, this "delinquent" had been arrested numerous times. He had abused a multitude of drugs and precipitated his hospitalization with an overdose of pills in what was termed a "suicide gesture." His psychiatrist was concerned about social withdrawal and believed Tommy was depressed. We were to encourage socialization and to be on guard against his "poor impulse control."

Tommy's father had deserted the family when my patient was five years old. His mother worked hard and made a home for the children; but she was described in Tommy's medical record as immature, provocative, manipulative, and self-centered. Vaguely, it was said that she was emotionally dependent on Tommy in ways that placed him in impossible double binds. On hearing the story, my first impression was that Tommy had been left too much on his own and that he was handling his plight in ways that were hurting him. His response so far to being hospitalized was described as angry and defiant.

Hearing this advance word on Tommy left me feeling uneasy, a little frightened. It was hard to imagine relating to a rebellious, streetwise, emotionally calloused, and remote boy who seemed to me vastly different and so much younger. I anticipated that the relative material and emotional indulgence of my life would make him uncomfortable or provoke hostility and that he would reject me. Did we have *anything* in common? What could we talk about? What did I have to offer him? Sybil said, "Just be his friend. Don't crowd him. Do things with him."

On meeting Tommy, my wariness quickly gave way. He did not look at all like a juvenile delinquent; he looked worried and weighted down. He had a slight, sinewy build and his pleasant face was more boyish than I had expected. His presence was not at all threatening. In fact, he

seemed lost and far away; and there was also something vulnerable and disarmingly appealing that drew me toward him.

The fact was that Tommy's eyes gave it all away. There was bottomless sadness there, but also within them something barely visible, like Plexiglas, between him and me. And yet what struck me most of all was that, from behind that barrier, Tommy seemed to be searching. There was a yearning for something that he tried to disguise but could not—or did not. He really looked at me, then did not. This contact was fleeting but unmistakable, and I took it to be an invitation to an engagement that could not then be fulfilled.

Our first conversation was superficial, awkward, halting, and distant. But afterward I felt more optimistic and understood my function in a different way; his invitation had redefined my role. Very quickly, Tommy showed me tacitly that my task was not simply to set limits and tolerate rejection, but instead to pursue emotional contact. He was definitely in there, so maybe I could reach him. It seemed that Tommy was rewriting my job description. I did not know then that our contact would redefine *me*.

Every day, I sought out Tommy and we played pool and basketball and gin rummy. He was good at pool and I was not, so we had a fast and real engagement based on his pleasure in defeating me and my trying to improve my game. After a few days, he began to greet me with a smile and to initiate our being together; soon we began to sit together in a private area for talks. He told me about his drug use, his legal problems, and about his girlfriend who had rejected him since he was hospitalized. Tommy also tried and failed to tell me things about his mother; he was just too knotted up to say much beyond an acknowledgment that he was "pissed" at her.

But the main thing was that Tommy talked and talked, now without hesitation. And I realized that when he was talking this way, the Plexiglas in his eyes disappeared; the contact between us was more immediate and full. I felt good about my part in this development, about the "job" I was doing. Sybil complimented me, and Tommy's psychiatrist told me I was a good role model for his patient. I looked forward to our conversations and soon began to feel a warmth and familiarity in my relationship with Tommy like those in my close, *personal* relationships. Slowly, he was

becoming more than a patient, and I more than staff. Each of us was becoming related to the other.

One evening, his mother paid a short visit, and after she left I noticed that Tommy was not around. I found him in his dark room, lying face down in bed, a shoebox on the floor. When I inquired, he handed me a crumpled, handwritten note: "Dear Tommy, I know how much you want these shoes so I bought them for you. The money I spent means that I couldn't buy groceries. It is very expensive having you in the hospital. Please get out as soon as you can. Love, Mom."

I told the back of Tommy's head that I didn't believe it was actually true about the groceries, that I knew he felt accused of making his mother suffer. In response, he cried convulsively while I sat quietly in a chair beside his bed. Those few exposed moments of an unguarded connection with his own emotion and with me were extremely intimate. I felt deep sympathy for Tommy, as well as gratitude to him for the trust he was placing in me, a trust that allowed my words to engage and to touch him. In retrospect, I think it was the first time I experienced anything like the protective love of a parent for a child or something of what is uniquely rewarding about being a therapist.

Now, Tommy and Sybil would show me more about the peril and the potential in this kind of intimacy.

TOMMY AND SYBIL

It was a frightening noise—an intrusive crash and thud—that resounded through the quiet ward. Sitting in the nurses' station, I could feel faint vibrations from some distant impact rush their way up from my feet to meet the quaking in the pit of my stomach. Instantly, staff gathered in the hallway, and I joined them just in time to see Tommy running at top speed down the long corridor toward a thick, wooden door to the outside. Just short of the door he threw his body into the air and, like a battering ram, directly against the immovable barrier. The jarring sound repeated itself and Tommy fell to the carpeted floor.

As we psych techs rushed toward Tommy with the shared intention of subduing him, Sybil stepped out of an adjoining room and stopped us. While he collected himself in front of the door, she asked us what

was going on; but no one knew. Sybil wanted to try talking before getting physical and told us to come with her as she approached Tommy, to stay behind her, not too close. When she was a few feet from him she queried softly, "What's wrong, Tommy?"

"Get away from me! Don't touch me! I'm getting out of here! *Leave me alone!"* Eyes flaming, he hurled the words. As Sybil tried again to reach him ("I'll help you, Tommy—let me tell you what to do"), Tommy stepped into an adjacent exercise room, where he armed himself with a chest expander and returned to stand defiantly in front of the locked exit, ready to fight against any approach.

Sybil was going no closer but continued to talk softly and calmly, when Tommy surprised everyone by swinging one end of his weapon in a wide circle. Before anyone knew what was happening, he moved forward and the heavy piece of wood he was wielding grazed Sybil's cheek, instantly drawing blood. At that, we all knew what had to be done; and within a few seconds our group had overpowered Tommy, dominating and holding him in place on the floor.

Sybil took charge of the situation, directing a specific person to take control of each extremity and urging us to hurry Tommy into the distant seclusion room where he might be safely restrained and sedated. It was a chaotic whirl of movement, fear, and noise. We five young men could barely hold on to and transport this one rageful and hyperadrenalinized, bucking and writhing adolescent who was fighting much more fiercely than seemed possible for someone his size. My assignment was the left arm; and, as I struggled to keep my grip and help move this desperate person down the hallway, I was suddenly struck by the terribleness of what was happening to Tommy—and to me.

For two months, I had devoted all my emotional capacities toward the careful forging of a therapeutic relationship with this guarded and vulnerable boy. I had poured myself into the task and into him, and I had been successful and felt proud of my accomplishment. It was clear that Tommy was benefiting from my efforts. It felt like one of the most worthwhile things I had ever done for anyone. I had become valuable *to* him and I had developed hope *for* him.

But something else quite unexpected had happened: the "therapeutic" relationship I was building with Tommy had also become a "real"

relationship for me, one that was vivid and even inspiring. With Sybil in the background, I was providing Tommy with an experience he had not had before, one that was intrinsically good and apparently helpful. And along the way, he had done something reciprocal for me, allowing with me a relationship, close in a way that gave new meaning and reality to my own preexisting notions of intimacy; in so doing, he had broadened my horizons by opening up new prospects, personal and professional, for my future.

I had not known that a "therapeutic relationship" could end up here, but Tommy and I had become *personally* important to one another. Each of us had found the other. Or so it had seemed.

And now all that had spiraled, uncontrolled, into this terrible moment: I was literally manhandling Tommy, probably causing physical pain in the process, certainly riding roughshod over his emotional sensitivity and distress. The suddenness with which I felt myself go from carefully building something good between us, to dismantling our fragile alliance and ruining the growing trust he had placed in me, was deeply disturbing. As the full impact of this awful realization hit me, I felt sickeningly destructive; it was almost as if I had come to my senses to find myself murdering someone.

At the very instant when all of this fell in on me, Tommy's eyes caught mine for the first time since the melee had begun. For half a second his face was still; then it registered shock, maybe horror. With his eyes now locked tightly into mine, the shred of his remaining restraint disappeared, releasing a penetrating torrent of "I *hate* you! I *hate* you! I *hate* you!" over and over, crying uncontrollably. Now, there was no doubt: I *had* killed our relationship. It was more pain than I could bear. My heart broke.

Thoughts ricocheted around in my head, no longer ordered and sensible; I felt nauseated and crushed, on the verge of crying, collapsing. I had often imagined damaging someone, but I had never anticipated being hurt like this. From within the maelstrom of this outer turmoil and inner catastrophe, now almost to the seclusion room, I felt a firm hand grip my shoulder, and I turned to see Sybil moving her face toward my ear.

Gently but firmly and very matter-of-factly, Sybil whispered to me, "He *loves* you."

Everything changed.

PSYCHOANALYSIS

Once again, Sybil had known exactly how to be; but this time I was the beneficiary of her way of being. I was the one in need of her help and the one she supported with her sensitivity and intuitive understanding. In the midst of a situation that undoubtedly involved her own sense of danger and emotional turmoil, as well as her immersion in the chaos surrounding us, Sybil had the presence of mind to think meaningfully and deeply not only about Tommy and his crisis, but also about me and mine.

Sybil's simple words were a communication to me that was—and certainly was intended to be—much more than a kindness or a comfort. Her response to me was no more a reassurance than her reaction to Cheryl had been a retaliation. Sybil was not denying the fact of Tommy's hatred; she was explaining it to me.

Sybil knew that I was in dire need and she responded by providing, at once, the information required to understand Tommy as well as my own experience of being understood. Her commentary suggested a new perspective, a more comprehensive and integrative grasp of Tommy's state of mind than any I could generate on my own. And while I thought the pain I was feeling was a private thing, the lyrical power of Sybil's words also told me that she understood my plight. In response to her grasp of me, I felt instantly restored; confusion gave way to clarity. Sybil's vision offered me a portal into a new universe of relatedness and meaning.

Before Sybil's comment, I did not know that someone could understand my feeling and respond to me in a way that could actually transform the profound and apparently absolute thing—the feeling itself. I did not know in any self-conscious way that one person could do this for another, that emotional experience was so potentially alterable. In that brief moment, I discovered fundamental things about Tommy (and all my future patients), about myself (and being a psychoanalyst), and about the crucial role of a third perspective in psychotherapy. As I was to

learn years later, psychoanalysts think about these things very abstractly, using concepts like ambivalence, projective identification, countertransference, containment, and interpretation. I doubt that Sybil thought *about* these things at all.

Though entirely unexpected, there was also no question that Tommy's hatred toward me was genuine. But until Sybil's words touched me, I was unable to see that love had anything to do with this eruption of hatred or with the therapeutic relationship I had with Tommy. As strange as that seems in retrospect, my blindness to those facts was one of the reasons why her simple comment—"He loves you"—had such a deep effect in me, both immediately and in its reverberations for forty-five years. Her alternative perspective added something true and essential that was missing; it gave dimension to my experience.

In the moment, the understanding Sybil offered instantly cleared my head, restored my sense of myself, anchored me, and opened my eyes much more fully to the real complexity, paradox, and irony that are intrinsic to emotional life. It was orienting and profoundly illuminating.

In other words, Sybil's thought was a thought that I was actually incapable of having, one that held and completed a crucial piece of the immediate emotional truth without which I could neither appreciate Tommy's feelings nor tolerate my own. Because she thought *for* me, I experienced directly a near-miraculous transformation: the homicide I felt I had committed was undone; the relationship was resurrected. Through her direct and compassionate emotional connection to me, I was given a reprieve. In her understanding and in her implicit acknowledgment of the inherent vagaries and vicissitudes of the love between Tommy and me, Sybil had been very *loving*. All of this came to me in three words.

Sybil was also teaching me, giving me a deeper knowledge that she knew I lacked, about the way people are. I had no animate or complex concept of an emotional ambivalence that is fundamental to close relatedness. I did not understand that intense love is often (or always?) accompanied by intense hatred; nor did I comprehend that hatred could be brought in temporarily to disavow a feeling of love, that the hatred could momentarily fill up a consciousness without permanently destroying the love. That such hatred (and such love) could be part of one's mind but unknown—unconscious—was a revelation.

It was new to me to realize that an all-consuming experience of strong emotion (Tommy's hatred, my broken heart) might be more than the literal and absolute thing that it was: such powerful feeling was all too real, but as it turned out, only a partial reality. Tommy's and my feelings actually had complex, interrelated, and complementary origins and meanings—specifically, my broken heart and brief collapse helped me know something about Tommy's. With so few words, Sybil had touched me deeply, taught me, and also had shown me, by example, what I would do in my life. I did not know then what it was called, but I wanted to be a psychoanalyst.

Nor did I know at the time that Sybil was providing me with on-the-job training about the fundamental importance in a therapeutic relationship of real, direct, and personal emotional contact between therapist and patient. She taught me about it by giving it to me. She helped me know and appreciate that my emergence from behind the protective Plexiglas barriers of professionalism and self-interest was a precondition for finding my way past the Plexiglas in the eyes of people like Tommy; I also learned that doing so left me exposed to serious occupational hazards. I could not remain guarded and safe and expect to relate meaningfully to Tommy's guardedness or to the dangerous feeling that lay behind his aggressive self-protection.

Psychoanalysis is often referred to as a "treatment." Accordingly, we search for the neurological basis of its action, and, lately, there is endless debate about its "effectiveness" and a seemingly insatiable demand for "evidence-based" justification for its practice. But it seems to me that despite its once central (and now increasingly peripheral) place in American medicine, psychoanalysis does not offer a cure for an illness. It is *more* than that. Sybil was the first to teach me this; yet as a psychoanalyst, I sometimes lose sight of it and have to learn the difficult, if basic, fact yet again: psychoanalytic therapy is not a prescribed set of technical operations that a doctor applies to a patient. While it often brings relief of symptoms, in its essence, it is not a treatment. If it were, psychotherapy would be a simpler enterprise—one much easier to learn, to do, and to receive; there would be a *technique* that led regularly to desired outcomes. If it were, it would not require the emotional resonance I first experienced with Tommy.

It is, instead, a specialized, complexly constructed form of intimate human contact—a way of being with an other—that opens a mind and stimulates and supports processes of psychic change. In their technical recommendations, psychoanalytic theorists—Freud, Klein, Winnicott, Bion, Kohut—have highlighted and codified different aspects of this way of being. But they did not *discover treatments,* or even new ways of being, as much as they *fashioned a novel way of relating* from selected elements found in other kinds of relationships.

The psychoanalytic partnership is ultimately constructed from naturally occurring, if complex, modes of relating; it packages and recombines elements that appear sporadically, or even reliably, in other human interactions. In psychoanalytic circles, it is a truism that one learns technique so that one can then *un*learn it—no irony intended. I think this is not generally true about the techniques of other kinds of "treatment," and to me it highlights the perspective that the techniques of psychoanalytic psychotherapy are nowhere near as important as is the way of being embodied by the therapist employing the techniques.

Many patients, of course, understand all this implicitly and naturally; and I have learned from them, too. Years after my encounters with Tommy, when I was a psychiatrist working on the inpatient service of a university hospital, a nurse approached me to ask if I had seen the newly admitted schizophrenic man having "clang associations." I had not seen this patient, nor had I ever seen *any* patient with this particular abnormality of thought. Fueled by a strong sense of academic interest, I eagerly rushed to the ward and found the frightened young man standing in the center of a large room.

The patient looked directly at me with eyes that seemed too clear to be afflicted with schizophrenia; then I disingenuously drew him into conversation with questions that were contrived. He dutifully obliged me with a quasi-spontaneous series of nonsense word sounds and rhymed answers—clanging.

When I had satisfied my curiosity and was about to walk away, he again looked into my eyes and said, very directly, "Excuse me. What's your name?" From behind the Plexiglas of my role, I responded to the "mental patient" with "Dr. Purcell." He shot back: "No, asshole. Your *first* name!" Exactly.

There are many versions of clinical psychoanalysis. The one least flattering to psychoanalysts, yet also most widely known, is the one popularized in jokes, cartoons, and movies. There, time after time, we find self-absorbed, narcissistic, objectifying analysts sitting (or sleeping) behind the couch, offering hurtful or inane pronouncements to their patients. It looks pretty disengaged and meaningless. And I suppose because psychoanalysis is sometimes done like that, such derisive representations are at least partly deserved. Humor and parody may be the most we can do to assuage the disillusionment implicit in these caricatures, a disillusionment that stems partially from analysts' misuse of a theory of mind translated too directly into the technique of a treatment.

Psychoanalysis conceived and conducted as a set of techniques used to deliver a "treatment" *must* be out of touch with something integral to the recipient's experience of emotional distress. However well intended, it cannot work like that; our emotional lives cannot be *treated*. One person's emotional experience can be shared, processed, thought, thought about, and apparently modified by an other; but it cannot be *treated* by an other. In its implementation, psychoanalytic practice is not as much about *pre*scription (for the patient) as it is about *pro*scription (for the analyst). As a "cure" for the maladies created by modern psychiatry, it cannot compete.

Sybil's version of psychoanalysis is not conceived as a treatment and is more to the point. Although it could be abstracted into theory or concretized by technique, it does not place theory-derived postures and maneuvers between analyst and patient. It demands personal strength and resilience, as well as clarity of purpose in the pursuit of a possibility of transformation through knowing, naming, and understanding what is emotionally true.

And while it could be conceptualized around goals of insight or symptom relief or any number of other good outcomes with which it is sometimes credited, it does not orient the analyst toward the deliberate induction of these elusive states of mind. Rather, it utilizes a highly individualized and ultimately intuitive appreciation of human psychic life to facilitate natural, constructive, and healing modes of relating.

Without a foundation in these relational and intuitive components, psychoanalysis can only be mechanical—a travesty of the powerful ex-

perience it might be. With it, there is the potential for the analyst's full and genuine engagement, which is prerequisite for a true and intimate emotional contact with the patient. I think Tommy was changed by our contact. I know I was changed by my connection with him and by Sybil's impact on me—her words still come to me, unbidden, in the emotional crises that comprise my daily work. Some summer job that was.

Freud, as he developed his understanding of the therapeutic action of psychoanalysis, realized that the value of transference—the intensely emotional relating unconsciously displaced from an important person in the analysand's early life onto the analyst—lay in its bringing alive in an immediate way the internalized versions of the otherwise unknowable, formative relational experiences of the past. But, while he recognized transference as providing crucial information about a person's psychic history, Freud also knew that change occurs in the reality of the emotional present; and he wrote of the impossibility of destroying one's inner tyrants in effigy.

With the evolution of Freud's approach, many analysts now believe that, in addition to deconstructing the relics of a pathogenic past, psychoanalysis can and must also build something new. The medium for the construction of new psychic structures is that of emotional *experience*. And while the irony and impossibility of emotional experience *in effigy* is patently obvious, psychoanalysis as a discipline has underemphasized the pivotal place of new emotional experience in psychic change. Perhaps the idea of the therapeutic effect residing outside of technique and firmly within the emotional dimension of the relationship has seemed too dangerous, just too unscientific. And, of course, there are real dangers inherent in the method.

As a psychoanalyst, I have come to think about interpersonal emotional contact as both the sine qua non of good analysis and also the hardest thing for an analyst to effect. Each successful therapy or analysis is necessarily an experience of negotiating barriers, of patient and analyst becoming related. Whereas it is defined as a relationship serving the *patient's* needs, the emotional substrate of the process is bidirectional: my patient must somehow give me access to his genuine emotion, which I must then take in, feel, and come to understand in a way that is also real and that allows me to convey that I am apprehending and appreciating his experience.

My academic knowledge of common mental mechanisms, forms of psychopathology, and "technique" assists me in this; used well, it helps me think and remain receptive. But the essential intercourse of psychoanalysis involves neither a relieving catharsis nor an intellectual discussion of psychodynamics. It is not a conversation about emotion, but rather an emotional conversing. It is a fundamental form of emotional exchange, of communication and relating—one that creates *en passant* something new.

Change through psychoanalysis requires the deconstruction and remediation of distorting and obfuscating psychic structures; but it also depends upon the building up of a new inner environment, an opening up and nourishing of psychic potentialities. Both dimensions require authentic emotional exchange as a necessary if not sufficient element of the process. The difficulty of finding this kind of real connection is daunting, and it is easy to become lost along the way. But the challenge must be met over and over; we are always *becoming* related.

In the end, psychoanalysis is a relationship—a potentially powerful one that is meant, among its several intentions, to have therapeutic effects. And yet, because it is fundamentally more alchemy than chemistry, it is too unpredictable—its effects too unknowable in advance—to be properly labeled a "treatment." It has as its focus the *patient's* anxieties, problems, and needs. But because it is deeply embedded in an intensely personal mode of close relating, it is fundamentally interdependent with and revealing of both the *analyst's* emotional capacities and limitations, and those of the analysand.

It is a difficult kind of relationship to conceive and live out. When it develops into its best expression, one having the qualities of Sybil's way of being therapeutic, it is an extraordinarily intimate and transformative experience for both people privileged to the encounter.

Acknowledgments: The author wishes to acknowledge and express his gratitude to Alice Jones and Owen Renik for their valuable assistance in the preparation of this manuscript.

2116 Sutter Street
San Francisco, CA 94115

e-mail: purcellsd@comcast.net

Volume LXXXIII, Number 4

THE "ME AND WE" OF PSYCHOANALYSIS: A COMMENTARY ON STEPHEN D. PURCELL'S PAPER

BY HOLLY CRISP-HAN

Keywords: Analytic understanding, *Member of the Wedding,* analytic training, preadolescence, analytic attitude, sense of belonging, analytic relationship, narrative, treatment, multiplicity of selves, isolation, self-awareness.

While reading Dr. Purcell's professional memoir, "Becoming Related: The Education of a Psychoanalyst," I was moved by his reflections on his first exposure to analytic ideas in a psychiatric hospital, mentored by a nurse who, though not psychoanalytically trained, was psychoanalytic in her approach. Hence in his description of Sybil, he formed an idea of how an analyst might think and work. Purcell had met a person who was sensitively attuned to the patient Tommy's needs as well as to Purcell's own needs. In Purcell's efforts to come close to Tommy, he came to know him as a person, not only as a patient. As he was drawn inexorably into the patient's feelings of love and hate, Purcell experienced the power of closeness in relationships, a formative influence that he would eventually carry over into his psychoanalytic understanding.

In musing on what I might write as a discussant of this paper, I recognized that my formative experiences followed a somewhat different arc than Purcell's and started much earlier in my development. I imagine each of us follows a different path, one that winds and twists through the course of our lives and has both conscious and unconscious determinants. Like Purcell, I can look back at moments in my life that were

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Holly Crisp-Han is an advanced candidate at the Center for Psychoanalytic Studies in Houston, Texas. She is a Clinical Assistant Professor in the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine.

turning points on the road leading to psychoanalysis, even though at the time these moments occurred, I had no concept of what an analyst was or did.

It is somewhat daunting to consider the task of writing a reflection on what has led me to analysis, particularly for an analytic audience, as each of us has a plethora of stories about how we came to this impossible profession, stories that we share in different contexts—some deep and personal, and others more acceptable in public company. I remember feeling shocked during my interview for analytic training when asked what experiences in my childhood and family had shaped my desire to become an analyst. Surprised, I took a deep breath and tried to find an answer that was honest without being too intimate, real without leading me to feel too vulnerable. So, in going forward with this written response, I find myself in a similar position.

As Purcell writes about his experiences, he conveys a sense of curiosity at becoming close to a stranger and at trying to contain and understand what it is like to be intimate in a way that one feels both love and hate. He describes a sense of the analytic attitude, the "peril and the potential in this kind of intimacy" (p. 793). In my own early experience, I, too, developed ideas about the analytic attitude and approach, without yet conceiving of psychoanalysis.

Through my childhood experience of reading Carson McCullers's 1946 novel *The Member of the Wedding*, I felt a wish for a sense of connection, a longing to belong, and a tension between being an insider and an outsider—all perspectives that I would later carry into my analytic work. The balance between the wish to connect and the need for isolation and self-awareness is critical in our analytic endeavor. As analysts, we create narratives with our analysands as a means of understanding and creating the self, a process that requires private introspection and collaborative interaction. The multiplicity inherent in the self, as conveyed in McCullers's novel, infuses our work with patients and can be integrated into a sense of self that allows for multiple perspectives while maintaining a sense of internal cohesion. Finally, unlike Purcell, I do believe that clinical psychoanalysis is a form of treatment, as this search for both the self and the connection with others can be profoundly transformative and healing in the context of a professional psychoanalytic relationship.

As a child, I would often retreat to my room and absorb myself in one book after another, immersing myself in imaginary scenes as if I were there. My mother would buy me stacks of books, and I would disappear for hours or days. I often read late into the night with a flashlight in the still silence of my bedroom after the rest of the family had retired for the night. One of the first books I remember reading was McCullers's masterpiece, the lyrical and honest story of Frankie, written in the post-World War II era and set in the American South. The reader follows Frankie, a young girl on the cusp of adolescence, as she grapples with being an outsider, lonely and lost, wishing to be part of a "we." As an outsider observing her brother and his bride, she feels a desperate wish for togetherness, wanting to be "a member of the wedding."

McCullers compellingly depicts the awkwardness of the preadolescent search for self in the longing to be part of someone else. She creates and re-creates Frankie as she seeks her own identity and longs for a sense of "we." The reader empathizes with Frankie's shifting perspectives of herself as she navigates the passage from preadolescence to burgeoning womanhood. This shift over time is accompanied by a changing voice: the character is written first as "Frankie," then as "F. Jasmine," and finally as "Frances." The following excerpt captures this transformation:

> The darkening town was very quiet. For a long time now her brother and the bride had been at Winter Hill. They had left the town a hundred miles behind them, and now were in a city far away. They were them and in Winter Hill, together, while she was her and in the same old town all by herself. The long hundred miles did not make her sadder and make her feel more far away than the knowing that they were them and both together and she was only her and parted from them, by herself. And as she sickened with this feeling a thought and explanation suddenly came to her, so that she knew and almost said aloud: *They are the we of me*. Yesterday, and all the twelve years of her life, she had only been Frankie. She was an *I* person who had to walk around and do things by herself. All other people had a *we* to claim, all other except her. When Berenice said *we*, she meant Honey and Big Mama, her lodge, or her church. The *we* of her father was the store. All members of clubs have a *we* to belong to and talk about. The soldiers in the army can say *we*, and even

> the criminals on chain-gangs. But the old Frankie had had no *we* to claim, unless it would be the terrible summer *we* of her and John Henry and Berenice—and that was the last we in the world she wanted. Now all this was suddenly over with and changed. There was her brother and the bride, and it was as though when first she saw them something she had known inside of her: *They are the we of me*. And that was why it made her feel so queer, for them to be away in Winter Hill while she was left all by herself; the hull of the old Frankie left there in the town alone. [McCullers 1946, p. 42, italics in original]

I remember reading Frankie's words and feelings as she awaited the wedding of her brother at a time when Frankie and I were the same age. I had no idea then that McCullers's novel was critically acclaimed as a sharp and poignant depiction of preadolescent development; I was simply absorbed in reading about Frankie. As she watched her brother and his bride, and later imagined them, she was overcome with the feeling that "they are the we of me" (p. 42).

Reading this book as a girl on the brink of adolescence myself, I felt awkward in my body (which was becoming foreign to me). My ideas were far more grown up in thought than in actuality. I felt both moved and unsettled by Frankie's desperate wishing. As she thought about and looked at the happy couple, she was certain that she was a part of them. She came to expect that they would invite her to be part of the wedding and that the three of them would move on to an imagined location together as a group, a "we" that included the young, lost, uncertain girl.

The words "the we of me" were curious to me. I remember repeating them to myself, turning them over again and again in my mind. I remember writing down the phrase, twisting the "me" upside down to make "we," caught by the repetition, poetry, and rhyme. Something about the phrase felt soothing and familiar. The intense wish to belong spoke to me. My life was nothing like Frankie's, but I could relate to wishing for a "we." I was connected to my family and my friends at school, but also loved getting lost in a book, intensely involved with the characters—the "we" of fantasy and possibility. Even reading about a girl wishing for "the we of me" must have somehow made me feel connected to others who longed for togetherness.

The wish for "the we of me" has been part of my journey toward analysis and a critical part of my analytic attitude. We are all fundamentally alone, and yet we wish to be part of someone else, to share our stories and our experiences, to know someone else's, and to feel a sense of connection. In our work as analysts, we must be able to sit with painful aloneness, both in our patients and in ourselves. The longing so exquisitely depicted by McCullers is part of our daily lives, holding and empathizing with the longings of our patients, listening and attending to our own longings.

The gradual unfolding of the analytic "we"—the interpersonal conscious and unconscious connection in the analytic dyad—is an intimate and life-changing experience. As we sit together over months and years, the analytic relationship becomes a location to nurture both the developing self, the "me" of the patient, and the path toward connection, empathy, and understanding: the "we" of a relationship that Freud noted was like no other. Inevitably, the self of the analyst is also changed in each analytic relationship.

While I can retrospectively see the origins of a psychoanalytic interest growing out of those magical nights of my youth when I was poised over novels with a flashlight, in a more formal way, my interest grew out of experiences in college and medical school. In college, I majored in history and literature, an interdisciplinary, combined program at my university that focused on reading a text, locating it in the historical-cultural period in which it was written, and seeing its qualities both as history and as literature. The idea was to take a piece of experience—a journal entry, a political manifesto—and consider what the piece could tell us about the author, his or her context and concerns, and the imagined audience. I learned to think about story and narrative as a way of generating and understanding meaning. I began to imagine the individual, the "me" in the "we" of the social and historical context.

As an analyst, I have the opportunity to approach each interaction, each moment, each sentence as a way that constructs meaning and tells a story. In co-creating a narrative with our patients, we are curious about the individual experience and the various versions of "we" that make up the patient's internal object world and the external reality in which life is lived. We actively participate in the narrative between the two of us

and use it to understand and reshape the various "we" experiences of the patient's past.

As analysts, we must sit with the tension between being an insider and an outsider. As a girl, retreating to my room to read, I was comfortable with silence and solitude. I also wished to be part of something larger than myself. I would later progress to involvement in musical activities, sports, and clubs in high school, comfortable in the transition back and forth between the "me" and the "we." Today the tension between being part of a group, a "we," and taking a more isolated stance is part of my daily experience as an analyst, but was also part of my medical training. In medical school, I had a disjointed experience due to taking time off in the middle of my training. I started with one class of fellow students, took three years off to pursue parenting, and later rejoined the program with a new group of classmates who had started several years behind my own class. I felt part of both classes, but also somewhat like a student without a class of her own. Further, in the era of subspecialties, it was uncommon to choose psychiatry as a career, and even less common as a psychiatry resident to pursue psychoanalytic training. Looking back on my training experiences, I can see the oscillation between isolation and connection, finding my own path versus returning to the path already set out ahead of me.

The dynamic oscillation between solitude and being part of a group was thus familiar to me—as a girl, as a college student, and in my training to become a physician and a psychiatrist. This oscillation has continued to be a necessary and important part of my daily work as a therapist and analyst. I live my days in intimate closeness with others. Yet I am also in solitude, in the quietness of my own thoughts and reveries, in the isolation of holding back some of my opinions and my own story, all the while being completely connected and absorbed in the interpersonal experience with my patient. The "we" of my daily work life in analysis is a "we" that is conscious, collaborative, and focused on the therapeutic alliance, while also being elusive, mysterious, and unconscious. I am "we" with my patients in ways that I choose and hope for, and also in ways that I understand much less clearly, or in ways that may at times be disconcerting for both of us.

Another aspect of "the we of me" experience in developing as an analyst is the search for the truth about one's self. In our own analyses and in those of our analysands, we realize that there is not one self, but a multiplicity of selves (Bromberg 2006; Mitchell 1991). As we delve into understanding our patients, we see a multiplicity of people rather than a sole, unified sense of self. We work on integrating those disparate selves, but also we seek to see, understand, and appreciate each aspect of self in close detail and curiosity. We understand that, paradoxically, one feels more integrated when one is fully aware of the various selves within.

Perhaps the strongest difference I have with Purcell's perspective is his questioning of the status of psychoanalysis as a "treatment." In my view, analysis is a life-changing experience of being part of a "we" that also deeply respects and seeks to understand the individual—in brief, it is based on a treatment relationship. Perhaps we disagree with how one defines *treatment*. He questions whether it makes sense to regard psychoanalysis as treatment if it is not a "prescribed set of technical operations that a doctor applies to a patient" (p. 798). He states that "one person's emotional experience can be shared, processed, thought, thought about, and apparently modified by an other; but it cannot be *treated* by an other" (p. 800, italics in original).

In my view, the "treatment" aspect of psychoanalysis encompasses more than techniques; it is developed from the deep attunement of one person to another. Contemporary psychoanalysts view the process as jointly constructed within an intersubjective dyad while also asymmetrical in its focus, since it is the patient who has come for help and who pays for the services of the analyst. Rather than viewing this joint process as precluding the designation of psychoanalysis as a "treatment," I view it as the very heart of what makes it a treatment.

By analogy, the wise general practitioner knows that the doctor–patient relationship is a necessary component of any treatment that is prescribed. Purcell's position is reminiscent of the age-old controversy of whether the therapeutic action of psychoanalysis is based on psychoanalytic technique—including, especially, interpretation—or on the therapeutic relationship. Most today would argue that the transformative effect of psychoanalysis involves both these aspects of the process.

As analysts, we are not friends or lovers or parents or children, though at times we may wear all of those roles in the transference and countertransference. We are professionals—psychoanalysts—in the most deep and intimate manner, informed by theory and technique, while being attuned to the "we" of the analytic relationship and the "me" of the patient.

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6750 West Loop South, Suite 460
Bellaire, TX 77401

e-mail: hollycrisphan@thegabbardcenter.com

Volume LXXXIII, Number 4

BECOMING A PSYCHOANALYST: COMMENTARY ON STEPHEN D. PURCELL'S "BECOMING RELATED: THE EDUCATION OF A PSYCHOANALYST"

BY ROBERT ALAN GLICK

Keywords: Psychoanalytic training, analytic attitude, therapeutic relationship, emotional engagement, analytic technique, transference, storytelling, self-examination, analytic pluralism, analytic process, therapeutic change, supervision.

INTRODUCTION

Learning to be a psychoanalyst has never been easy. Admittedly, Freud, in the beginning, simply anointed those he trusted and then empowered his anointed to follow suit.[1] However, over the past century, as psychoanalytic theory and clinical work grew necessarily more complex, Freud and his followers became protective and systematic with his creation. They went on to codify a more structured canon of psychoanalytic theory of mind, of psychopathology, and of analytic technique and process. Prospective analysts, apprentices as much as students, came to rely on a training analysis to provide the required discipline they needed to explore and unleash dangerous primitive drives.

Much has changed in a century. Models of psychoanalytic training were established, disseminated, challenged, and revised. What generations of psychoanalysts learn has grown much more complicated, deeply personal, and dramatically less tethered to a set of rules derived from au-

[1] Freud trusted those whom he believed had a capacity to read and decode the unconscious.

Robert Alan Glick is the former Director and a Training and Supervising Analyst at Columbia University Center for Psychoanalytic Training and Research, as well as a Professor of Clinical Psychiatry at Columbia University.

thoritative theories. While not exactly freewheeling or "wild," becoming and being an analyst can feel more like being at sea in the dark, with only the stars (and one's own emotions) as a guide.

Teaching someone to be a psychoanalyst has similarly changed dramatically over this time. In retrospect, I look back at my teachers and my teachers' teachers and imagine that they had it easier than psychoanalytic educators today. Armed with less theoretical clarity and less technical certainty, educators now must prepare future analysts for a less-well-defined profession and for a decidedly less receptive and more impatient and skeptical world.

Today, becoming an analyst requires learning to create a peculiar and uniquely self-conscious relationship. Both participants must work to engage in an odd and yet candid conversation about that conversation. This experience (at times surreal), when developing effectively, promotes the patient's self-reflection, emotional insight, personal growth, and freedom from self-constricting patterns of suffering.

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In his compelling professional memoir, "Becoming Related: The Education of a Psychoanalyst," Stephen D. Purcell recalls moments of emotional relating that led to his becoming a psychoanalyst. He also advances a polemic about psychoanalytic teaching and the process of learning to be a psychoanalyst, suggesting that psychoanalytic training is failing to place sufficient emphasis on "intuition, emotional receptivity, empathy, [and] relatedness" (p. 783), and further, that the field and its educators are mistaken in considering psychoanalysis a *treatment*.

Ultimately, this memoir is also an example of the psychoanalyst's responsibility and his craft. Purcell shows his curiosity and desire to tell and retell his story, and in this way, he illustrates the method by which one makes sense of oneself to oneself. The author's narrative process demonstrates an analyst's unrelenting search for meaning and for an understanding of himself as an instrument of his work.

Of the many ideas this memoir stimulates, I have chosen the following that seem most interesting to me and relevant to my experience as a psychoanalytic clinician-educator:

1. Psychoanalysts' fascination with memoirs and storytelling;

2. The issue of relatedness and its place in an analytic attitude;
3. The polemic: psychoanalysis as treatment or not;
4. The challenges of teaching and learning psychoanalysis.

MEMOIR WRITING AND STORYTELLING

Analysts seem particularly drawn to storytelling. In this memoir, we encounter the author working as an aide in a psychiatric hospital. He is an innocent seeker who ventures into a strange (under)world of madness and alienation. He meets Sybil, the head nurse. He portrays her as a mythic prophetess who will guide him, protect him, and teach him the magic art of healing. He suffers and learns as he attempts to help Tommy, a patient—a traumatized, suffering lost soul—recover his humanity.

Sybil has a seemingly preternatural power of observation and control. She is a mind reader and a sorceress: "With her sensitivity and intuitive understanding," her "presence of mind to think meaningfully" (p. 796), and her vision, she offered the author "a portal into a new universe of relatedness and meaning" (p. 796). In this way, she becomes the consummate teacher, offering a brilliant example of analytic supervision. Among her lessons are:

- We humans ambivalently crave and fear intimate attachments, and this leaves us in unrelenting unconscious conflict;
- In this conflicted state, we should never deny the hatred that accompanies love, or that cure comes through acknowledgment and tolerance;
- Our emotional relatedness is a healing instrument, and as we seek to understand how to help those trapped in their suffering, we should appreciate the deep complexity and irony of the human experience;
- And, ultimately, "real, direct, and personal emotional contact between therapist and patient" (p. 798) has significant therapeutic power.

As in all such stories, the young hero finds himself suddenly in a dangerous crisis, one in which he experiences terror and painful loss followed by a transformation. No longer ignorant, he is sent on his way changed, strengthened, and humbled.

This memoir is an ode to an idealized, demigod-like teacher whose power transforms the author. Idealization, in one form or another, is a near-universal student experience. It plays a significant role as one becomes a psychoanalyst.

I am reminded of another near demi-god whose wisdom is therapeutic and growth promoting—this one an outstanding fictional treatise on the moral education of children. In *To Kill a Mockingbird* (Lee 1960), Atticus Finch, Scout's single-parent attorney father, like Sybil, demonstrates near-magical powers of observation and control as Scout faces terrors, injustices, and harsh realities. His ultimate lesson resonates with Purcell's: "You never really understand a person until you consider things from his point of view . . . until you climb into his skin and walk around in it" (p. 30).

These stories, like an analysis, follow an individual's journey from innocence and cherished ideals, through crises of disillusionment and loss, and then recovery and maturation, with a deeper knowledge about life, and growth.

As other readers may find in reading Purcell's article, I was immediately drawn back in time to my own "prepsychoanalytic" experiences that reflect the meaning and value of our storytelling natures. Purcell's memories (and mine) are screen memories, which serve to embody and narrate a more complex and hidden weave of our sense of ourselves.

When I was a medical student at the start of a psychiatric emergency room rotation, an elderly woman shuffled in late one hot summer night, dressed in a housecoat and slippers, carrying a large shopping bag. She was quite upset with her husband, who was said to be harassing her with lewd sexual demands, and she "could not stand it any more!" I felt confused and acutely concerned for her. I also felt pained by her obvious distress and wanted to be of help. (Coincidently, in the months before this moment, I had lost cherished grandparents.)

As I started to ask the woman predictable medical student questions, she impatiently and with formidable irritation stood up and, completely destroying any semblance of composure I thought I had, handed me

her shopping bag, saying, "Here! *You* take him!"—and hurriedly padded out into the night. As she left, I panicked that I had failed to help her, and then I looked in the bag and saw a metal canister that contained her husband's ashes. I was overwhelmed with confusion, sadness, and a sense of poignant irony about the mysteries of love, loss, sex, time, and deep attachments.

From childhood until the end of life, we thrive on stories and storytelling. As children we are read to, in order to put us safely to sleep so that we need not fear the dark. We listen to, watch, and play at adventures of our magical proxies, our avatars, and ourselves. These adventures are moral tales, vital lessons about right and wrong, good and bad, wishes and fears, illusion and reality, truth and falsity. We tell our stories of ourselves to ourselves (as well as to others) to internalize and integrate who we are.[2] Storytelling has always been a part of our nature as human beings who seek and create meaning.

As Schafer (1992) suggests, our neuroses are rigid and painful story lines, personal myths and narratives in which we have imprisoned ourselves. Psychoanalysis becomes an iterative process that offers a path out of these neurotic constraints, a mode of rediscovering and re-creating personal stories to relieve suffering. One tells one's story to the analyst, and the analyst tells it back with crucial revisions that reveal deep and empathic alternative understandings. In the process, the analysand learns to use the analyst's mind, his mode of relating, to retell his story to himself. Effective analysis is ultimately iterative storytelling in which the suffering listener finds a new capacity to recast the meanings of his own stories.

RELATEDNESS AND AN ANALYTIC ATTITUDE

Since psychoanalysis crossed the technical/theoretical border from a one-person psychology into the world of a two-person psychology, much

[2] Narration is in our brains, if not actually in our bones or blood. Steven Pinker (1994) suggests that our brains are built to create language that will embody stories of ourselves as subjects interacting with the world of objects—including our bodies. Damasio (1999) posits that some form of proto-self-experience of interaction in the world allows for the creation of a conscious and self-conscious, self-reflecting capacity to know and learn about the "I and me" acting in the world.

has been gained (and perhaps some things lost). The gains were probably latent for a considerable part of psychoanalytic history. The "two-personness" remained implicit, alluded to, and probably quietly acknowledged in the choices that analysts made in their referrals to one another since the earliest days in Vienna.

Freud recognized that analysts must have a receptive capacity for unconscious communication, both from the patient and in relation to themselves. He worried that unexamined participation of the analyst (in the form of unconscious infantile wishes and fears) could burden, interfere with, and ultimately destroy not only a particular analysis, but also the whole movement. Therefore, the analyst needs analysis to inform him about his own unconscious!

Receptivity to the patient's unconscious communications enables the analyst to decode the patient's symptoms, dreams, and behaviors and reveal the infantile drives.

From Ferenczi to Strachey on therapeutic action, from Fenichel (1945) on intuition in technique to the object relations theorists, through the self psychologists, Klein, Bion, and the relational-interpersonal-intersubjectivists, the idea of co-participation has matured, developed, and evolved into empathy, attunement, containment, and relatedness.

As psychoanalytic experience and thinking deepened, definitions of countertransference grew less pejorative and more inclusive. The concept of mutual participation gained an indispensability for the analyst at work. Now, like much else in modern life, we ask how we ever got along without it. Greenberg (2012) summarized the sweep of analytic history in North America:

> The new appreciation of the interactive elements of the analyst–analysand engagement, and in particular of the nonverbal communication of early dynamic themes, led to a sea change in the way in which the psychoanalytic situation was practiced as well as in the way it was conceptualized. [pp. 31-32]

As Purcell makes very clear, the impact on the analyst of the patient's emotional engagement with him, the loss of protective distance, is the signature of emotional relating. The analyst must feel himself living with

the patient in the analytic process, not just as an objective observer gathering useful information about the patient's inner life.

Purcell positions relatedness as the analyst's essential capacity, but in this memoir he does not venture into its sources, problems, limits, etc., and he runs the risk of overstating his case. The danger here is that relatedness could be seen as not only vital, but also as the lion's share of an analytic attitude. We do not want to replace the lost epistemic authority of the one-person psychology with a new conviction of the unchallengeable truth-value of relatedness. The analyst's experience does not consist simply of tuning in, being empathic and engaged; he may feel storm-tossed and lost, frightened and angry, desperate, or enthralled and needy—any of these feelings and more.

What defines these feelings as part of an analyst's proper work (Friedman 2008) relies on the oft-sited concept of negative capability (Keats 1817): the willingness to tolerate and embrace uncertainty and ambiguity without grasping for answers, clarity, or—worse yet—certainty. The analyst holds fast, steps back, and tries to understand what is at play here.

Purcell traces a path from becoming related to becoming an analyst. "Becoming related" necessarily asks "related to whom or to what"? The analyst needs to keep asking: what is being sought, desired, feared, protected, avoided in the relating—what do I want or not want? What is it that is pursued here? It is a kind of anatomy or physiology of relatedness that the analyst seeks to know.

A necessary skepticism and curiosity allow the analyst to explore the uses and misuses that the patient seeks to make of the analyst in the unconscious narrative in which the patient has cast the analyst. This essential, boundaried, and disciplined quality of relatedness becomes a significant challenge for psychoanalytic educators to impart and for psychoanalytic students to master.

Schafer (1983), a master teacher of psychoanalysis, has described the analytic attitude at length. Here are a few of his comments:

- This work is done by human beings who, fortunately, are neither machines, saints, nor romantic heroes. [p. 5]
- A desirable degree of subordination of personality will be evident in the analyst's remaining curious, eager to find

> out, and open to surprise. It will be evident also in the analyst's taking nothing for granted (without being cynical about it), and remaining ready to revise conjectures or conclusions already arrived at, tolerate ambiguity or incomplete closure over extended periods of time, accept alternative points of view of the world, and bear and contain the experiences of helplessness, confusion, and aloneness that not infrequently mark periods of analytic work with each analysand. [p. 7]

- The analyst aims to be helpful—analyzing is not an alternative to being helpful, it is the analytic way of being helpful. [p. 13]

The analytic attitude requires looking at oneself in the process of relating. It is this, the self-reflecting, self-narrating quality that creates an analytic attitude; otherwise, the analyst is just like anyone else in the patient's life affected by his emotions. The analyst must do the hard, disciplined work of stepping back when he can and examining his participation, his inescapable subjectivity (Renik 1993), which shapes the action in the process. We may seek to be our best analytic selves, our most "analyzed" selves, but we always remain ourselves.

PSYCHOANALYSIS AS TREATMENT: A POLEMIC

Psychoanalysis has always had its controversies, and in important ways, it has survived and been enriched by them. Today, productive debates continue to challenge how and what analysts believe about theories of mind, about the problems of theoretical pluralism, and about the effective application of theory to clinical analytic process. Uncertainty remains about the active agents of therapeutic action and what makes for positive change. There is lively discussion about the value of knowledge from beyond the boundaries of psychoanalytic process (e.g., from cognitive neuroscience, child development, and cultural and social anthropology). Intense debate continues about the destructive effects of power politics and ideological struggles within the profession.

Papers and panels continue to address the analyst's participation in and epistemic confidence in the sources of the transformative effects

of psychoanalytic process. And, certainly, there is an ongoing effort to define and deliver optimally effective psychoanalytic education (Auchincloss and Michels 2003).

But as I see it, there is little argument over psychoanalysis as a treatment. Purcell states that:

> Psychoanalysis is often referred to as a "treatment". . . . Psychoanalytic therapy is not a prescribed set of technical operations that a doctor applies to a patient . . . . In its essence, it is not a treatment [!!!]. [This is true because] If it were, psychotherapy would be a simpler enterprise—one much easier to learn, to do, and to receive . . . . It would not require the emotional resonance I first experienced with Tommy. [p. 798]

While I agree that analysis is a "complexly constructed form of intimate human contact—a way of being with an other—that opens a mind and stimulates and supports processes of psychic change" (p. 799), analysis well practiced is neither a mechanical use of technique nor simply a mode of relationship, nor is it only insight. And it is certainly not alchemy! At its best (and like most activities relying on education), it involves an internalization of knowledge, skill, and technique. And, once mastered, the best informed and most skilled technique becomes natural and invisible.

I believe that Purcell has conflated or confused method with goals. The issue hinges on the definition of *treatment*—what is a treatment and how it is taught, and most important, how it is learned. All effective treatments, in medicine, surgery, and psychotherapy, for example, even the use of placebos, draw on interventions that stimulate and support, but that also crucially rely on inherent structures and functions that mediate therapeutic outcomes. All human relationships have emotional impact—good, bad, or indifferent. Psychological trauma, developmental arrests, and developmental failures are all the result, at least in part, of the impact of forms of human relatedness.

My problem with Purcell's position is not the centrality of the relational and intuitive components of psychoanalysis. Nor is it with the central and defining role of the lived experience of the transference in analytic process—the patient's internal life must come alive in the room,

in both participants' experience of the relationship. As Loewald (1960) suggests, the spirits of the underworld must drink the blood of the living to come alive and tell their story. The therapeutic action of psychoanalysis seeks to turn the ghosts who unconsciously haunt the individual into ancestors within his personal history.

People seek out analysis, however reluctantly or circuitously, to relieve their suffering, particularly in their modes and capacities for relating to themselves and to others. They pay in time and money and emotional commitment to find relief, even as they fear and resist change. But the heavy lifting, the essential work of analysis is the patient's (not the analyst's!) struggle to recognize, acknowledge, and learn about himself from a new perspective—this perspective arising from and through the relational process of analysis. The patient must attach himself to the analyst's capacities—especially his curiosity—in order to change his story and change his mind.

Poland (2013), highlighting the role of curiosity as a particular aspect of the therapeutic process of analysis, states: "As a result, psychoanalysis is defined by the *how* an analyst explores, not by *what* the analyst then finds. And the patient learns that *how*" (p. 830, italics in original).

The very private ways in which the patient experiences, challenges, battles with, and slowly, "secretly" internalizes capacities of the analyst form the elements of therapeutic change.[3] Analysis is a treatment because the patient uses it to repair, heal, modify, etc., the problematic aspects of his capacities.

THE CHALLENGES OF TEACHING AND LEARNING PSYCHOANALYSIS

Purcell gives a vivid picture of the lessons taught by Sybil and Tommy that initiated his journey into psychoanalysis. His story includes a series of moments, a sort of mini-introductory curriculum, that illustrate the launching of an analyst's education. He highlights among many experiences: surprise as the doors of the mind open and apprehension about

[3] Most theories of therapeutic action since Strachey and on through Bion involve the patient installing and borrowing elements of the analyst's mental structures, capacities, etc., mediated through their mutual interaction to effect growth and change.

what will be found inside; the profound sense of ignorance and of feeling lost and afraid; confusion about the apparent reality of the relationship and of mutual emotional impact that is troubling; recognition of the power of the irrational, of a violent hatred that lives alongside deep, dependent attachments; the cruelly applied power of the patient to change a good analyst into a bad analyst; the fact that sympathy does not cure; the challenge of continuing to quietly, patiently, and subtly observe; the ability to see below the surface and to make layered meaningful inferences; and the complexity of the caregiver's relationships with teachers, supervisors, mentors, and analysts.

Purcell is correct that the student analyst must learn to recognize, acknowledge, and interpret his own experience in order to understand the patient's experience, and then use it to strengthen the patient's tolerance for and access to his own inner mental life. As noted above, the appreciation of fundamental "two-person-ness" of analytic process has deepened psychoanalysis immeasurably and has made the experience of learning to become an analyst so much more personal and ultimately rewarding.

One of the challenges of developing an analytic attitude, including its essential and unique relatedness, is appreciating its inherent therapeutic influence. It is not something apart from a healing practice. In psychoanalytic education, like many apprenticing forms of learning, students must let go of and unlearn other ways of being helpful and attempting to heal the patient.

While the fact of complex participation and how to convey this is one of the greatest challenges in psychoanalytic teaching and learning, I believe that Purcell paints an unfair and reductive picture of psychoanalytic education today when he suggests that psychoanalytic education has not sufficiently emphasized relatedness as a crucial part of learning to be a psychoanalyst.

SEMINAR TEACHING

Let me give two examples from seminars I have taught that attempt to deepen a student's knowledge and skill in recognizing how "becoming related" is active and useful in clinical work. True to Purcell's perspec-

tive, both examples are forms of storytelling—as are all process seminars (which may be why they are more enjoyable and participatory for both students and teachers). Both seminars involve presentations of clinical process material to highlight the nature and impact of the analyst's participation in the analytic process. The goal of both is to reach an appreciation of how modes of relating draw on both formal analytic concepts and on personal emotional involvement in an important synergy.

The first is a seminar on countertransference and therapeutic action. The more specific objective of this seminar is to explore and illustrate the ways in which recognized—and, more important, unrecognized—countertransference reveals a latent theory of therapeutic action used by the analyst to help or "cure" the patient. It focuses on "what we are (or think we are) doing when we analyze"—a particular source of mystery in general and pointedly so in the minds of analytic students.

In one class, as the instructor, I presented an example from a long and complex analysis of a young, traumatized man who was gaining a capacity for a deepening loving attachment that was moving toward marriage. I related that the treating analyst, in exploring a particular dream about the patient's fiancée, mistakenly called her by the name of the analyst's married son's prior long-standing and much-admired girlfriend (not his wife!). The patient made the obvious correction and wondered how the analyst could make that mistake. The analyst (privately thrown by such a telling slip) acknowledged his error and the value of the question, which he said he would explore (though not directly with the patient).

What the analyst realized once he regained his "quiet analytic composure," was his complex investment in wanting to be the patient's unambivalently loved father. He had been aware of a sense of therapeutic pride in helping the patient attain this goal. On uncomfortable self-reflection about the slip, he was forced to acknowledge that, in his wish to replace the failed, rejecting father, he had a more problematic, ambivalent oedipal wish. The analyst's father had been absent for two years during World War II. The slip revealed a chronic enactment that paralleled the patient's profound, competitive oedipal wishes and fears hidden in his wish to be a better father.

I shared with the class the opportunity to see more clearly what both the analyst and the patient might be struggling with. The students were fascinated with a senior analyst's candor that allowed them to see the power of relating as it generates anxiety and insight in both participants. In particular, this example reveals the implicit theory of therapeutic action in a commonly enacted countertransference wish—i.e., the analyst's effort to be a new and better replacement object, a variant of Strachey's (1934) model of incorporating the analyst as a more benign superego.

The second seminar (Glick and Stern 2008) is the final component of a five-year program in "Writing as Pedagogy." This program seeks to demonstrate the value of writing. Making a commitment to writing allows the student to discover what he thinks and to construct a creative "a-story" of how he understands the clinical process. (Purcell's memoir is a fine expression of that effort.) In this pregraduation seminar, the advanced candidate writes up one of his longer analytic cases. The seminar group explores the analyst's participation through the written case summary, with particular attention to potentially unrecognized transference-countertransference interactions inferred from the writing. It is an effort to see modes of relating in the analytic process. In the seminar process itself, the group has likened the experience of learning to analyze to the story of "The Sorcerer's Apprentice," in which an apprentice sorcerer (the candidate-analyst) naively unleashes dangerous forces and is ultimately rescued by the sorcerer (the supervising analyst).

An interesting feature of the seminar is the way in which the class discerns from the written summary the implicit problematic countertransference experience not explicitly described. The group process affords a safe interpretive space for the candidates to show and be shown difficult enactments in the analytic process. The most common group observations include the analyst's fear of his aggression and of losing the patient; the belief that the analyst's simply being a "good new object" will heal the patient; the candidate's unconscious identification with the patient's devalued self; the too-hot-to-handle triadic transferences often played out in supervision; and patterns of chronic mutual enactments used to protect against dangerous desires and disruptive rage.

All these and others, as they are addressed in the group, give voice to unacceptable feelings embedded in the mode of relating, and allow

for deeper understanding and working through that is reflected in the required revisions of written summaries.

THE TEACHING OF THEORY

If learning to become a psychoanalyst involves relatedness, participation, and the development of an analytic attitude, what is the role of teaching and learning theory in this educational process? Curriculum committees debate the educational relevance, relative emphasis, and sequencing of psychoanalytic theory of mind ("metapsychologies") that are supposed to support and explain clinical process. Educators and students wrestle with the optimal level of immersion in theory in the education of a psychoanalyst: is there too little or too much Freud, Klein (original and modern), British Middle School, Bion, Lacan, Kohut, etc., etc.? Should theory be taught chronologically as an evolving knowledge that seeks to answer fundamental analytic questions about the nature of mind, its development, and its disorders? Or should theory be taught as a series of core concepts relevant and useful to current analytic practice?

In my opinion, we do our best these days when we teach psychoanalytic theory(ies) not as sacred or objective truths, not as scientific-based rules, but as useful conceptual tools, languages, vocabularies, or mental maps that guide the analyst at work. Our theories are our best efforts to make sense of mental life, its structures, functions, and process. Well used, our theories allow us to step back from the immediacy of participation and to be able to think, to make sense of our experience.[4] Michels (2006) likens theory to "teddy-bear" transitional objects (p. 413) that comfort the distressed analyst.

Creating/discovering meanings is what the analyst offers the patient. As has been suggested, it is the internalization of the pursuit of meaningfulness, not the specific meanings, that is a therapeutic effect of analytic process and interaction.

Writing about the unconscious vicissitudes of theories in learning to be an analyst, Grossman (1995) cautions educators as follows:

> As with acquiring any kind of knowledge about "reality," learning analysis is a creative process. Understanding theoretical ideas is

[4] See Sandler (1983) on public and private theories.

> piecemeal and selective, and resembles insight . . . . The analyst's relation to theory will be dynamic, ongoing, and reflective of the history of the process of learning psychoanalysis. This is an endlessly evolving task, like one's own analysis. [p. 886]

SUPERVISION

Students start training anxious and insecure, often with little psychodynamic clinical experience. Analysis is something they *undergo* and not yet something they know how to *conduct*. Mystification and defensive idealization accompany early phases of training, including the training analysis, and emerge in supervision. I have written previously about the training analysis in particular:

> Considered the fundamental analytic learning experience, the training analysis is a most peculiar blend of apprenticeship, rite of passage, intimate emotional attachment, and therapy . . . [It] is a situation ripe for insufficiently analyzed idealizations . . . . Training analysis is supposed to set in motion a process that creates and propels self-reflection, maturation, flexibility, and emotional receptivity. [Glick 2003, p. 385]

Supervision is often the forum where one has the opportunity to address a candidate's mystification and idealizations. Grossman (1995) cautions:

> It is precisely in the situation of teaching and learning a theory and a method of applying it [i.e., supervision] that models *of the way in which things work* become *ideals, models to be emulated* in thinking and in practice by the student. [p. 894, italics in original]

In the long and arduous educational process of analytic training, all students need ideals and embodiments of those ideals in teachers and mentors—analytic "gods" who possess the wisdom and power to teach students the secrets of the profession.

Looking back over thirty or more years of supervising, I find that the most striking change in my pedagogical focus and style supports Purcell's attention to "becoming related." As I have grown more aware of, interested in, and comfortable with the vagaries of my own partici-

pation in analytic process, I have a deepened conviction that the anxieties that influence candidates' learning, as evidenced in supervision of the analyses they conduct, stems from confusion and uneasiness with their own emotions in the process. However well they have learned and mastered theory and the theory of technique, students seem to gain the most freedom and creativity, the most room to think and relate, when they can see and learn from their immediate engagement in the analytic process.

Like Purcell's younger self working under Sybil's guidance, candidates in supervision often fear exposure of their understandable emotional responses. They can experience themselves as wanting to induce, seduce, cajole, or in some way force certain feelings on or into the patient. They want to change the patient's mind through their caring authority. They do not want to recognize or acknowledge the role in which they are placed (Sandler 1976) or the emotions that are induced in them.

As the following two examples illustrate in a familiar way, the supervisor's task is to give analytic legitimacy to the student's emotional participation in the process.

A candidate in supervision described feeling that she wanted the patient—a very challenged and depressed woman—to have more hope. Sessions had recently focused on the patient's bitter sense of futility about life and about the analysis. The candidate was ashamed that she dreaded meeting with the patient, and did not know what to do. Should medication be reconsidered? Was analysis the wrong treatment? As we discussed theoretical approaches to this problem and the candidate became open to looking at and thinking about the analytic interaction, she could employ the conceptual tools offered by Klein, Bion, and Kohut to gain an understanding of her experience. She saw that it was necessary to live with her sense of despair in order to move forward with the patient.

Another supervisee described a patient's edgy eagerness while giving a pressured report of "superficial events" that had occurred during a two-week break in the analysis. In supervision, the candidate acknowledged a surge of impatience as he listened to the patient remind him of who certain people in his life were, as if they might be unfamiliar

to the analyst. The candidate gently encouraged the patient to get on with more substantive material. In an odd and uncomfortable way, the candidate felt that he was being experienced as new, unfamiliar, and potentially threatening to the patient. He had the thought that the patient saw him as someone dangerous and controlling, whereas he felt that he had been quite helpful to the patient thus far in the analysis. Armed with this awareness once the situation had been discussed in supervision, the candidate could think more comfortably about the patient's internal experience of their relationship, and could employ his new understanding to deepen the process.

When supervision goes well and involves mutual learning, supervisors can see imitation giving way to internalization, and students learn to "forget" technique, to develop their own natural style as analysts. As the student learns to be himself in the work, there is a quiet sense of adventure, a thrill of discovery. (A different version of this is hopefully also true for the patient in the process.) As occurs in storytelling, as discussed earlier, the analyst begins to appreciate a creative sense of uniqueness—that he is having an experience uniquely his own, never before seen or known with this other person, the patient.

Analysis can feel like our own particular discovery, our own invention. Similarly to many of our developmental experiences as human beings—learning to walk, to talk, to understand, to keep secrets, and to magically influence others with our words and deeds—learning to be a psychoanalyst changes us.

CONCLUSION

In writing this memoir, Purcell illustrates the essence of the psychoanalyst's desire and of his craft. His attention to relatedness, so central in becoming a psychoanalyst, is movingly expressed here in the pursuit of an ever-deepening understanding of himself as an instrument of the work of analysis.

In writing about idealization and psychoanalytic learning, I have suggested (Glick 2003) that beyond the formal structure of analytic training—i.e., personal analysis, seminars, and supervision—being a psychoanalyst involves continuous learning from our work with patients

and students, and, importantly, from life lessons drawn from our experiences of ourselves and others in our lives: from "complex, layered, and sustained relationships," and from "powerful and transformative adult experiences, both ours and our patients,' that significantly reframe our perspectives, our judgments, and our interpretive inquiries" (p. 397).

In this way, our "becoming related" continuously evolves and changes, often in quiet but powerful ways.

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125 East 84th Street
New York, NY 10028

e-mail: rag4@columbia.edu

Volume LXXXIII, Number 4

MARRYING INTUITION AND THEORY: ON THE ROAD TO BECOMING RELATED

BY LEE SLOME

Keywords: Intuition, theory, analytic relationship, analytic training, supervision, psychodynamics, omnipotence-impotence, analytic frame, identification, treatment, intrapsychic experience.

It is a great pleasure and an honor to be asked to write a discussion of Stephen D. Purcell's evocative article, "Becoming Related: The Education of a Psychoanalyst." His rich memories and reflections offer us a peek into the personal and emotional experiences that helped shape him as a person and, ultimately, as an analyst. It is a beautifully written reminder that unconscious relational tracks are often laid down very early in our clinical experiences and can prompt new intrapsychic awakenings.

Dr. Purcell's memoir made me wonder what experiences inspire a person to become a psychoanalyst and what encounters shape that path. I also appreciate his perspective that universal, standardized techniques in psychoanalysis are a fallacy because, as he demonstrates in his memoir, the starting place for each analyst is highly unique.

In this discussion, I look further into Purcell's description of his relationship to Sybil, the head nurse on the unit where he worked, and the central importance of strong supervisory experiences in analytic training. I then offer an alternative perspective on analytic stance: one that cycles between emotional, intuitive involvement and the use of theory and intellectual thought. Using relevant theory, I describe how this cycle manifests in the analytic couple across several overlapping dimensions: omnipotent and impotent extremes in the countertransfer-

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Lee Slome is a graduate of the Psychoanalytic Institute of Northern California in San Francisco, California.

ence, analytic turbulence related to frame disruption, and the analyst's unconscious reciprocal need for the patient. Finally, I briefly address the question that Purcell raises of whether psychoanalysis should be considered a treatment.

NOTES ON MY BACKGROUND AND ANALYTIC TRAINING

Before discussing Purcell's article, I want to share the relevant clinical encounters that shaped my experiential path. Many years before my psychoanalytic training, when I was young and eager, I, too, spent time in the belly of the beast, training in psychiatric emergency clinics in San Francisco and, after licensure, as an attending psychologist at an inpatient psychiatric hospital in Alameda County. Exposure to the raw vulnerability of the human psyche on an inpatient psychiatric unit is intense—and almost indescribable. In my day, the unit in the public hospital where I worked was highly dangerous, so paranoid patients and paranoid staff coexisted in a tinderbox of projections. There was little room for personal relationships or analytic thinking, nor tolerance for momentary regressive jags in a patient's recovery. I was changed by these experiences and, like Purcell in his relationship to the patient Tommy, I have distinct memories of cases that captured my curiosity and drew me in.

Much later in my career, after more than fifteen years of practice as a psychologist, I sought analytic training at the Psychoanalytic Institute of Northern California, graduating in May 2013. Purcell emphasizes a propensity in psychoanalysis to downplay emotional receptivity and relatedness in favor of idealized theories, rote techniques, and neurobiological explanations for experience; by contrast, I was fortunate to attend an institute that offers a broad acceptance of pluralistic ways of thinking and the multitude of analytic perspectives. I had room to develop my own idiosyncratic analytic style without shame or fear of rigid, antiquated rules. Through my training, I gained a deep and scholarly knowledge of psychoanalytic theory and technique. In my experience, rather than operating at cross purposes, the theories I learned and my intellectual development over the course of training actually brought me

closer to my deeper intuitive self and helped build confidence in my natural sensitivities and receptivity to the inchoate.

As an analyst, I have a powerful susceptibility to form involved, personal relationships with my patients. Over the course of my training, I took on psychosomatic, old, young, wild, and difficult patients and then proceeded to invest, intellectually and emotionally, in each of them. They represented the kinds of cases most analysts would not want. I tended to have a die-hard attachment to each of them and their potentials, despite what at first seemed like low odds for a successful treatment.

Purcell's emphasis on the necessity of and resistance to compassionate emotional engagement with patients is a topic I have thought about extensively. Motivated by a strong desire to understand more about myself as a clinician and to investigate the concomitant risks and benefits of my tendency to invite patients under my skin, I wrote my graduation paper about countertransference tsunamis in which the analyst's psychic life is overtaken by preoccupation with his/her patient. When weathered, tracked, and eventually made more conscious, this cycle in which the analyst is swept away, loses balance, and then works to recover promotes slow, iterative shifts in the patient's (and analyst's) emotional functioning.

My early clinical experiences in acute care—and, much later, my clinical and theoretical work in psychoanalytic training—confirmed my natural interest in working with primitive states. My discussion here will reference several ideas born of these experiences and reflect what I have come to understand about how patients change.

SYBIL AND THE FUNCTION OF THE EARLY SUPERVISOR

Purcell's relationship to Sybil as instructor, mentor, and identificatory object reminds me of my supervisory relationships during my analytic training. Supervision with three fundamentally different but all idealizable analysts proved to be the single most transformative and significant aspect of my training. All three offered a respectful, supportive environment in which I could share the details of my work. I felt free to expose my most difficult personal dilemmas and countertransference storms.

When working with regressed patients and when overcome by regressive pulls, the analyst may find that symbiotic mutual dependency and transference-countertransference love within the analytic couple can collapse perspective. Supervision opens up triadic, observational space in which to avoid unabated merger or overidentification. The activated need between patient and analyst is mirrored in the analyst–supervisor relationship so as to provide the analytic couple with a ripple effect of containment. The runoff of too much to hold in the analyst is caught by the supervisor, clarified, and returned.

There is nothing like working the graveyard shift to bond clinicians to each other and create the conditions for trust and intimacy. In the article, we see Purcell witnessing Sybil's embodiment of confidence and security within herself and a trust in her own intuitive self, unrestrained by self-doubt or fearful overthinking. And her supervision gave Purcell step-by-step guidance, leading him gently toward intimate involvement with Tommy. Sybil's encouragement was like a manual for how to forge a relationship with a fragile person when both of you are scared to make contact. And when Tommy erupted in unbridled aggression, she continued to be available to Purcell. Maybe Sybil's comment that "he loves you" was so transformative and powerful because it was as though she were saying, "*I* love you."

Indeed, intense personal involvement with unstable patients is tricky business. It requires immense support and relational availability. If only we all had a Sybil available in our theoretical nurses' station for us to go to on the heels of a particularly flooding session—the kind of person we need when we lose our bearing and get swept away by the immediacy and adrenaline of the patient's state of mind. In my opinion, an intimate relationship with an ongoing consultant is often the best method to maintain some semblance of analytic balance.

One of my supervisors is particularly akin to Sybil. She is deeply intuitive, unflappable, and always leads with love and understanding when listening to case material. Our consultation is focused on one particular case, a wildly manic teenage patient, and she has accompanied me five sessions a week for more than four years. As I struggle to detangle overwhelming dynamics—a byproduct of the patient and me deeply inter-

penetrating each other's unconscious lives—my supervisor has been a generous, steady presence.

Despite her broad scholarly knowledge of theory, her supervisory style is rarely infused with intellectual explanations. Surviving the regular upheavals of love, hate, shock, hurt, and worry between the patient and me has necessitated what some might consider excessive contact with my supervisor. Some weeks, I leave her multiple messages detailing the latest episode of analytic turmoil. Sometimes I request advice and a return phone call, but mostly the messages offer me a place to put overwhelming countertransference experiences and help remind me of the supervisory container so that I feel less alone. Never critical or judgmental, my supervisor maintains tremendous faith in my clinical instincts, and her grounded, straightforward approach has led the treatment slowly forward. My personal, intense involvement with the patient, accompanied by the Sybil-like maternal provision of my supervisor, has shepherded the patient toward greater emotional regulation, impressive self-reflection, and a much saner, more functional life.

How fortunate for the young Purcell to have encountered a supervisor like Sybil with her capacity to bring security and relational holding to patients, to him, and to the entire milieu. When working in the trenches of primitive psychic processes, consultation is an absolute necessity. But to my mind, growth as a result of psychoanalysis involves more than Sybil-like intuitive and personal talents.

MARRYING INTUITION AND THEORY

Purcell's article portrays an idealized version both of Sybil, who embodies an honorable, atheoretical analytic stance, and of the clinical use of analytic intuition. In this vein, it is tempting to make a false dichotomy between theory or intellectual thought and personal, intuitive relating. Several aspects of the article prompted me to reflect on my own analytic style and how I do or do not use my knowledge of theory to reflect on what is happening in a given case.

Although I believe in the use of the intuitive self as a prerequisite for growth and the discovery of emotional truths, I also see a strong need for self-analysis and the application of theory to understand unconscious

processes. I view the process as an iterative phenomenon, as follows: necessary overinvolvement, overidentification, and unconscious co-mingling with the patient eventually prompt upheaval in the analytic couple, followed by differentiation and eventual recovery. Analytic theory and alternative ways of thinking about the dynamics at play allow for space in which to think and learn from the emotional experiences generated between analyst and patient.

In the example of Tommy's rageful eruption, a retrospective deconstruction of the complex, unconsciously driven states that led to the crash would help his care-giver critically evaluate what projective mechanisms or undigested elements led to the disturbance. What happened to trigger Tommy's crisis? What was the climate of his body (psyche-soma), of the hospital unit (frame), of internal object relationships, external relationships, and the therapeutic relationship? How was his emotional connection with Purcell implicated in the upheaval? Was there room for the use of practical and technical knowledge through self-analysis, supervision, reading, and other explanations to assist Purcell in regaining his equilibrium? What happened after the restraint and seclusion? How did the "analytic couple" recover and repair the rupture? These are some of the theoretical questions I would want to investigate in this clinical situation.

I am using this as an example to show how Purcell's paper may drift too far in the direction of privileging intuition and emotional experience without recognizing its essential connection to theoretical understanding. Overreliance on an analytic stance based on intuition and our personal relational qualities has the risk of blinding the analyst to unconsciously driven patterns that emerge within the analytic field. I imagine that this is not Purcell's intent; rather, the paper reveals a difficulty in avoiding splits when writing about such ideas.

From the infinite number of unconsciously informed dynamics, I will focus on three potential patient–analyst configurations that I have come to experience in my work with patients not unlike Tommy: alternating cycles of omnipotence and impotence within the analytic couple, the tension between the frame and therapeutic countertransference love, and the benefits and pitfalls associated with the analyst's need for the patient.

RHYTHMS OF OMNIPOTENCE AND IMPOTENCE

It takes a certain amount of analytic hubris to personally invest in fragile patients and imagine helping them via a close relationship. Heartfelt involvement with our patients and omnipotent fantasies toward them are often born of countertransference love. Omnipotent belief in oneself and in one's patient is a natural, developmental process created by a strong wish for the patient to get relief from suffering. These illusions will necessarily be ruptured by certain conditions in the analytic couple bringing forth the exact opposite emotional valence in the form of analytic impotence.

Of course, it is impossible to separate the patient's omnipotent fantasies from the analyst's. Often the patient's idealized projections dovetail with therapeutic zealousness and add fuel to the analyst's omnipotence. For the purposes of this discussion, I am focusing on the analyst's omnipotent fantasies and the countertransferential crash-and-recovery cycles that, when survived, benefit the patient.

Overzealousness and a willingness to offer hope and faith in the analytic process are important qualities in analysts who dare to treat primitive patients. Repetitive progressions and regressions in the analytic relationship occur as omnipotent illusions inevitably collapse and eventually reform, only to crash again. I am describing a type of omnipotence that is less like Klein's (1935) ideas of grandiose omnipotence and more like Winnicott's (1971) ideas about magic and omnipotent illusions. Analytic omnipotence might manifest as a fantasy that the analyst can control the outcome of a case, or that he/she can heal the patient with love alone. Or maybe even that analyst and patient will *both* be healed through the relationship.

It is this cycle of love, identification, and overinvestment in a case, followed by a crash and recovery, that helps the patient grow. Growth is predicated on the analyst's ability to tolerate both the omnipotent desires toward the patient and the impotence of watching the patient collapse without taking things too personally or experiencing unjustified guilt.

It strikes me that Sybil—and eventually, in his relationship with Tommy, Purcell as well—relied on omnipotent fantasies in order to push forward with the work. So when Tommy required physical restraint of his destructive, raw aggression, Purcell was crushed by the limitations of his capacity to protect the growing love between them. It left him vulnerable to responsibility, guilt, and a feeling of having personally destroyed the patient and their therapeutic relationship. And though Sybil had the presence of mind to explain Tommy's hatred toward Purcell at that moment, I wonder whether she may have misjudged the situation, too—overconfident that her soothing words would de-escalate the patient as they always seemed to do. Maybe this was an example of her omnipotence at work.

Eigen (1985) described this phenomenon in which attempts at mastery and their breakdown are quickly pulled toward omnipotent-impotent extremes. He highlights the patient's unbearable dread of loss of control and complete impotent helplessness. It is the analyst's "imaginative leaps" that help the patient gradually bear difficult emotions within the cycles of pseudomastery and collapse. Eigen puts it as follows: "Ideally, as time goes on, positive aspects of omnipotence interact with humility and fuel creative activity" (p. 159).

A point that Purcell's paper has prompted me to think about is that repetitive dramas between analyst and patient along the omnipotence-impotence dimension are to be expected and lived through. When the omnipotent illusions are crushed and the analyst is forced to confront analytic impotence, a systematic après-coup engagement with theoretical concepts can help the analyst bring to awareness the interplay between felt power and powerlessness within the analytic dyad.

THE PLACE OF THE FRAME

Overreliance on intuitive engagement may lead to a failure to consider another aspect of the analytic field: the delicate balance between the frame and a personalized adaption to each patient. Purcell's memoir did not mention the frame as an essential component of his work in the hospital and his relationship with Tommy. Given the times and the kind of facility, I imagine it may not have been talked about in such terms, despite its essential importance.

All psychotherapeutic relationships require a set of ground rules and parameters for the security and containment of the analytic couple. However, many patients need care that goes beyond the usual accommodations in order to meet their hunger for special, highly personalized, attuned attention. Motivated by an awareness of the therapeutic importance of love, the analyst may choose to break the frame and examine what happens rather than upholding an inflexible, universal frame. On the other hand, while it is sometimes necessary to flex the frame, the analyst's overinvestment in loving fantasies can make the frame conditions ripe for upheaval. Even minor variability in the mutually agreed-upon frame may seem on the surface to be compassionate to the patient's needs but can provoke confusion, psychotic symptoms, or even violence.

Bleger (1967) conceives of the frame as a silent bulwark in which the patient's psychotic self is contained—a nonprocess, background object that is not seen or consciously known but is necessary for change. The analyst is to maintain the frame with consistency and firmness to offer the conditions for a symbiotic, growth-promoting relationship. When the patient's primitive, personal "family institution" eventually bumps up against the agreed-upon analytic frame, the patient's "ghost world" (Bleger 1967, p. 512) is revealed in the form of psychotic symptoms or disorientation. These disruptions offer analyst and patient an opportunity to investigate the background conditions that have been invisible until then.

In comparison to our private practices, inpatient psychiatric hospitals offer an entirely different setting for our patients, but the same concept applies. Purcell did not elaborate on the parameters of the hospital unit where he came to know Sybil and Tommy, but we have to assume there were plenty of them—predictable daily routines and clear behavioral expectations of the patients. Even with a frame that includes 24-hour coverage, firmly boundaried rules, dispensed medications, and a contained milieu community, patients are sensitive to cracks and inconsistencies. Given Sybil's personalized adaptation to each patient, she strikes me as the kind of clinician who would bend the frame according to her intuitive judgments of what might build relational trust. We cannot know exactly what precipitated Tommy's uncontained emotional upheaval. But maybe when he slammed against the locked unit door, his primitive

family frame was colliding with the analytic frame, revealing his previously unexplored sensitivities.

ANALYSTS NEED LOVE, TOO

Intimacy born of therapeutic appreciation and love for a patient is extremely seductive. It stimulates unconscious wishes for love, healing, and reparation in the clinician as much as in the patient. Intuitive and personal involvement with patients can sometimes be motivated by the analyst's desire for reciprocal reparation. In fact, though usually in a way that is out of our awareness, we all need our patients for specific emotional reasons. Patients sense this and respond by helping us, consciously and unconsciously.

Searles (1973, 1975) explored the mirroring of the maternal relationship in the patient–analyst interaction and the therapeutic benefits of reciprocal identification. He bravely wrote about the analyst's need for a mother/therapist in the patient and how the relationship can mend the analyst's unconscious troubles so that he/she can then become the analyst/mother whom the patient needs. On a primitive level, these analytic relationships are unusually therapeutic and transformative for both analyst and patient.

It is important for the analyst to fall under the spell of mutual dependency, symbiotic love, and the promise of mutual reparation. It is a natural process, like the symbiosis between mother and baby, and it allows for both analyst and patient to feel of value to each other. But when the analytic couple hits a bump in the road—for example, a disruption due to a separation—we need to reach for our analytic books to breathe fresh air into our thinking and to detangle the patient's need from our own.

Purcell was drawn in by Tommy's vulnerability and palpable need for emotional contact. In this case, reciprocal identification helped Tommy gain confidence in his inherent worth and helped Purcell transform emotionally. Consciously, Purcell thought he was simply trying out a somewhat scary job. But perhaps unconsciously, he was drawn to that hospital position because of a curiosity about the primitive parts of himself. So, whether or not he knew it at the time, maybe he was gutsily

exploring his own deeper internal world, seeking self-knowledge and healing.

THE TREATMENT OF A PATIENT

It seems to me that we should guard against a false division between psychoanalysis as a "treatment" and, as Purcell puts it, a "complexly constructed form of intimate human contact" (p. 799). From my perspective, these descriptions are synonymous. Maybe this reflects progress in our field such that psychoanalysis is now administered within the context of more contemporary relational models. But we all still refer to it as such—"this patient has been in treatment with me since . . . ," etc.

Maybe we need to consider the other definition of *treatment* when describing psychoanalysis: how one person behaves toward another person. This is less like surgical treatment and more like the ethos or way in which a person is being treated. For example, in the current climate, psychoanalysts are less likely to give their patients the "silent treatment" based on old-school norms of analytic neutrality and impersonal reserve. Our behavior toward our patients, how we handle or care for them—this "treatment" would seem to line up with the complexity of the definition Purcell is promoting.

CONCLUDING REMARKS

The concept of "becoming related" as a lifelong developmental process fits with my experience of building faith in myself and my clinical skills. From this point of view, discovery and invention of ourselves over time is an ever-shape-shifting challenge. Prompted by a disruption or confusion, I reach back to past traditions and theories to offer myself different ways to organize my thinking about a clinical interaction. I shape my analytic stance accordingly—sometimes getting help from theoretical concepts or technical advice, and sometimes breaking completely free of them by relying on internal cues. From my perspective, the toggling between confidence in our instincts or intuitions and use of theories or frames of intellectual reference is the meat of becoming an analyst. As a result, I am gradually learning to trust myself and my deeper intuitive capacities, so that who I am tends to be more dominant than what I know.

Reflecting on early and sometimes even recent life experiences is a very specific psychological activity. As we recover, reexperience, or rework memories and relational or intrapsychic experiences, internal links are created. Optimally, with each reremembering, some previously unexplored facet is discovered and felt that allows for new emotional awakenings. It is this prismatic shifting of lens and gleaning of new perspective that makes the process of psychoanalysis so rich and gratifying for patient and analyst alike.

Purcell's piece is a beautiful reminder of how to look back and learn something from an emotional event experienced long ago. His memoir has inspired a retrospective investigation of the clinical influences and training experiences that have molded me into the analyst I am today. I think all clinicians can deepen their work by engaging in this edifying process of cycling back and connecting the dots of past influences with current and even future perspectives.

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5835 College Avenue, Suite A
Oakland, CA 94618

e-mail: leeant@mindspring.com

Volume LXXXIII, Number 4

THE PATIENT'S OBJECTS IN THE ANALYST'S MIND

BY NANCY KULISH

In every analysis, the analyst develops an internal relationship with the patient's objects—that is, the people in the patient's life and mind. Sometimes these figures can inhabit the analyst's mind as a source of data, but at other times, the analyst may feel preoccupied with or even invaded by them. The author presents two clinical cases: one in which the seeming absence of a good object in the patient's mind made the analyst hesitate to proceed with an analysis, and another in which the patient's preoccupation with a "bad" object was shared and mirrored by the analyst's own inner preoccupation with the object. The use and experience of these two objects by the analyst are discussed with particular attention to the countertransference.

Keywords: Internal objects, transference-countertransference, analytic interaction, analytic relationship, characters, self- and object representation, internal world, unconscious identification, gaslighting, introjection, object relations, analytic narrative.

It is the nature of the psychoanalytic enterprise that the inner lives of analysts and patients become enmeshed. In the transference, the countertransference, and the therapeutic interaction, we come to represent objects to each other. This phenomenon is the core of the psychoanalytic process, and as such it takes center stage in our clinical reports.

Yet in every analysis, the analyst develops an internal relationship not only with the patient, but also with the patient's objects, that is, the

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Nancy Kulish is an Adjunct Professor in the Department of Psychiatry at Wayne State Medical School.

people—parents, spouses, children—who occupy the patient's life, feelings, and thoughts. Here I use the word *object* to refer to the internal mental representations of these people and to internal object relations.

We look constantly to the ways in which we and our patients become each other's objects, but not so much to this related phenomenon: that our patients' objects also become part of our inner experience (Jacobs 1983). Sometimes these figures present themselves comfortably to us as a welcome source of data about the patient's mind and life; at other times, they seem strangely absent or formless. Sometimes the analyst may become preoccupied with them, finding him- or herself thinking about them often, or in extreme cases may feel totally invaded and overtaken by sadistic, controlling gangsters (Rosenfeld 1971). Such experiences always reveal something about the patient's internal world, but if the analyst's view of these figures, and his or her relationship to them, becomes too fixed, it can become a challenge to listen flexibly and openly to the patient's psychic reality.

In my view, several interrelated factors contribute to why and how our patients' objects seem to migrate from their minds into our own: the nature of the patient's inner objects and object relations; the state of the transference and countertransference; the analyst's technique and theories that guide his or her thinking; and the analyst's personality and state of mind. It seems to me that in the present here and now of any analytic relationship, not all inner objects or object relations of the patient are available, visible, or active. Transferences that impart these objects shift; for complex reasons that relate to patient *and* analyst, one constellation may be more salient in one analysis and to one analyst than in another analysis and to another analyst. A failure of the analyst's experience of the patient's objects to shift, due to countertransference, may lead to stalemates in the process.

Ferro (1992) is one of the few psychoanalysts to write about these phenomena. He describes three different analytic models for interpreting "characters"—the patient's objects—in the analytic narrative: the structural, after Arlow (1985), in which the characters are understood as living people around which conflicts revolve; the Kleinian, in which characters are "de-codified" and can be understood as projections of bodily phantasies onto or into the analyst (I am using *phantasy* here in

the specifically Kleinian sense); and Ferro's own relational-unsaturated analytic field theory.

I find Ferro's model particularly helpful in thinking about the clinical situation. Ferro (1992) likens the patient's objects to characters that appear in a narrative: "The character in a narration is both a construction of the text and a reconstruction of the reader" (p. 70). The analytic narrative, then, is the text written by the patient as author and the analyst as reader. As they appear in the text, the patient's objects are both a construction by the patient and a reconstruction by the reader/analyst. This metaphor appeals to me because it captures the complexity of the transference-countertransference situation from which the characters—the patient's objects—come to life in the analyst's mind. These characters, even though they emerge from the patient's narratives, are co-created by the analyst.

Emphasizing these complex mutual interactions between analyst and patient, Jacobs (1983) writes explicitly about the analyst's experience of the patient's objects. He explicates how the patient's objects can have a variety of meanings for the analyst, which can become potent forces in influencing his or her reactions to the patient. For example, the process of reconstruction of the patient's history may be significantly influenced by the analyst's perceptions of the patient's objects. The analyst's inner representations of the people in the patient's life may reactivate oedipal conflicts and material concerning the analyst's own family. As Jacobs summarizes:

> Not only are they [the patient's objects] related to self- and object representations past and present, but they may, in his [the analyst's] imagination, be part of a network of interactions involving the patient, his family, and other of his objects as the result of the reawakening in the analyst of fantasies, memories, and expectations derived from his sibling and family relations. [1983, p. 641]

Jacobs makes another important observation: he suggests that the analyst's unconscious identifications with the patient's objects may contribute to countertransference responses that are *especially hard to detect.* Parallel to a splitting of the transference, there may be a splitting of the

countertransference, as an object in the patient's life becomes the target of one side or the other of the analyst's personal ambivalences.

In this paper, I will illustrate these ideas with an exploration of two vivid experiences that I had with objects in the minds of two of my patients. I focus on my countertransferences that shaped my experiences of these objects and created difficulties in the analytic process. I will track my inner responses and fantasies about a key object of each patient, link these responses with what was going on in the analytic field—in the changing transference-countertransference interplay—and speculate about what the changes in my experience might have meant and what psychic functions they played.

Shifts in my internal experience of the patients' objects seemed both to reflect and even to bring about developments in the analytic process. While I was not consciously aware of it at the time, in both cases, I sought out and even created my own version of my patient's object as a way to cope with puzzling and highly distressing elements in the relationship between the two of us.

CASE 1: TOM

My patient Anna was in her late fifties, divorced for twenty years, with two grown sons. She conveyed a deep emptiness and depression. In her presenting complaint, however, the only concerns she mentioned had to do with her relationships with her sons and her new daughter-in-law. Her older son and his wife spent many weekends enjoying Anna's backyard pool, and she was so terrified of alienating her son that she felt unable to tell him that it was too much. She was also afraid that Tom, her current boyfriend, was getting fed up with the young couple's constant presence.

I soon discovered that such fears that people in her life would become angry with her and leave her dominated Anna's mind; within a few weeks, she was having these fears about me as well. I also learned that Anna had made a serious suicide attempt while her marriage was breaking up, and that she had a sexual encounter with her marriage counselor (a male) at the time. On her way home from that incident, she had said to herself, "Now it is truly hopeless," and made the attempt on her own life.

These specific anxieties aside, however, the patient appeared totally flat. All affects were absent, and it appeared that she had no words for feelings. The patient herself did not use the word *depression* at all, yet depression was there as a palpable presence.

After several months of psychotherapy, I began to think that Anna should be in analysis. But I hesitated, asking myself whether she would be able to tolerate the opening up an analysis would bring, and worrying about her suicidal potential. In a move unusual for me, I sought a colleague's advice about the wisdom of starting an analysis with this patient. Without conscious intent, I picked as my consultant a man whom I knew to be optimistically convinced that analysis was for everyone, so naturally he advised me not to hesitate to begin. In retrospect, I am sure that what I was really asking was whether *I* could tolerate the intense affects and deep depression that I anticipated I would have to live through with this patient. I did not understand this at the time.

From the very beginning, the analysis was marked by Anna's profound terror of abandonment. Our first break, around Christmastime, brought the conviction that I would never return. As she felt in relation to everyone in her life, she feared I would leave her if she displeased me in any way. Her constant preoccupation was that she would drive me away. "Whatever I say, you won't like me," she whispered.

As Anna's history unfolded in bits and pieces and over many months, I began to understand her depression, her seeming emptiness, and her fear of abandonment. She related her history at first with a bare-bones outline of the major facts, and then with snippets of data and memories, loaded down with unspecified affects. I will summarize here the history that we constructed over time of the patient and her objects; this history's coherence emerged only slowly. The emerging narrative helped me make sense of my patient's pained presentation and my inner experience of her.

Anna's mother had abandoned her at birth because she did not want a baby, especially a girl. This history was openly acknowledged in the family. Only after ten or twelve days did the paternal grandmother collect her from the hospital. Anna's mother did not have anything to do with her care; Anna's father, who worked long hours, hired a nurse who left when Anna was probably about eighteen months old. Some

time later, a full-time housekeeper was hired; she stayed with the family throughout Anna's childhood, and Anna continued to maintain a close relationship with her. Anna could retrieve no early memories of her mother, only memories stemming from later childhood.

Her father was the only parent whom Anna felt she had, and she appeared to be attached to him. A traumatic incident had occurred early in their relationship. She reported what I labelled as a screen memory from the age of three: she was sitting on her father's lap, and he was tickling her. As she recounted this, she wondered if she had become sexually excited (and I wondered if the father had gotten excited). Her father pulled away, declared an end to the tickling and cuddling, and her sense was that he had totally shied away from any such physical or affectionate behavior from then on.

Anna said that her father often referred to her as "oversexed." Yet she felt that he "liked" her and was pleased by her accomplishments. Much later in the analysis, we came to understand that the sexual encounter with her marriage counselor was a reenactment of this early trauma. Her thought that "Now it is truly hopeless" reflected her feeling that she had lost her father, in a way, as well as her mother.

Throughout her childhood and adolescence, the patient reported, she was left almost totally to her own devices. She remembered wandering the streets alone as a child with the money her father had given her for food in her pocket. Her mother was an alcoholic and her father a heavy drinker; the parents "partied" all the time. Anna described her mother as an angry, bitter person who clung possessively to her father and was jealous of any attention he gave to Anna. He provided her with whatever money she needed during her growing-up years. He died a few years before Anna and I met, and her inheritance funded her analysis.

In the first months of the analysis, what I experienced was primarily the patient's profound sense of insatiable emptiness and unarticulated badness. The objects in her current life—her sons and her boyfriend, Tom—were described in terms of her terror of their disapproval and potential abandonment of her, but they remained fuzzy in my mind. These fears of abandonment and her unhappy demeanor conveyed a sense of depression that seemed to infuse the consulting room. As mentioned, her affect was generally flat; at times she would weep, seemingly incon-

solably, without any clear connection to what she was saying. My concern was to make sense of her flat emptiness.

In the first year of the analysis and for several years to follow, on many occasions, the patient exhibited unusual behavior during her sessions, which was painful to watch. She would writhe and rock wordlessly on the couch. As I explored this behavior with her, I realized that it was a re-creation of her frequent masturbation, bodily based and without visual content. She experienced a painful something, an almost tangible substance, inside herself—like a kind of abdominal cramp. The most basic sensation was of an insatiable "sexual" feeling—an emptiness that could not be filled, but that impelled her to masturbate to relieve the tension. She had the fantasy that menstruation might help: blood flowing out would help, being rid of something inside would help. Her masturbation gave her only temporary relief and left her feeling frustration and pain in the belief that she could never be satiated.

It was not possible to be in the room with this person, trying to come into contact with her unbearable sense of emptiness, without feeling a sense of desolation myself. I needed history, theory, insight—something quantifiable to help us both. So I began to interpret this bodily feeling, especially as it came up in the transference, as an early longing to be fed, cared for, and contained by me as a longed-for mother. Also, I began to focus on Anna's nameless sense of intrinsic badness that would drive people away—a badness that stemmed basically from her being female (the basis for her mother not wanting her), her intense sexual feelings (called "oversexed"), and her anger (as yet unacknowledged).

I understood Anna's feeling of an insatiable emptiness that could never be filled as a fantasy, yet at this point I was worried about it. I wondered whether it might be an expression of a developmental lack of psychic structure (Tyson 1996), and whether her inability to verbalize her affects was a consequence of unrepresented, unsymbolized, or inchoate mental states (Bion 1962; Green 1998). More than being worried about the meaning and implications of her emptiness, I felt uncomfortable—alone at sea and in need of something to hold on to.

Even the patient's descriptions of the people in her life at present seemed amorphous, vague, and flat. She talked a lot about her two sons, so I was forming some picture of what and who they were. But of

Tom, her boyfriend, I had very little sense. He seemed a dim figure to me—just *there*. Anna complained vaguely about him: he was reliable but boring and uncommunicative. She hinted that sex with him was only so-so. However, he was moving in with her, and there was a likelihood that they would get married.

Then came a session in which I experienced a sudden insight about Tom. Anna was planning to make some renovations to her home, for which she had to obtain approval from the community zoning board. The morning after a public hearing in this regard, she reported what had happened. Tom had gone with her to the hearing. She had been very nervous and stuttered when she got up to explain her rationale for the changes to her property. Several men on the board had given her a hard time; they fired questions at her and it appeared they would vote against her. She had become flustered.

Tom, usually a quiet man, had then asked permission to stand up to speak. When the board had asked what his interest in the matter was, he had said, "Well, I am the man who intends to be with this lovely woman for a long time. I intend to move in and marry her." The members of the board had laughed and subsequently approved her request.

Anna told me that she thought Tom had turned the tide not so much by his words as by the impression of respectability and solidity that he conveyed. Then she began to talk about her old housekeeper.

As I was listening, words suddenly came into my head like a bolt of lightning that lit up in my mind: "*He loves her!*" I do not remember what I actually said at that moment, but I think I murmured something to this effect aloud: "*He loves you.*"[1]

From that moment on, I felt Tom's presence in Anna's life more clearly—as a solid, supporting, and loving man. And I experienced his presence within myself as well—as a comforting anchor in a sea of emptiness, a psychic ally in the psychoanalytic enterprise.

In retrospect, I realize that I was searching for a sense of some sort of good internalized object in the patient's mind, which *I* needed her to have. It was painful to bear witness to her absolute terror of abandon-

[1] Birksted-Breen (2012) described sudden visual or dreamlike images that appear in the analyst's mind during reverie—images that offer a meeting ground between the concrete and symbolic in patients who demonstrate an absence of symbolic thinking within the analytic situation.

ment and to her internal emptiness in an area where any positive, caring object might dwell. Certainly, she could not find a positive image of her mother anywhere in her mind; I saw only a void where such an imago might be.

I think my words, "He loves you"—and, more important, my accepting attitude toward her—conveyed a complex message. First, it gave her my permission to be loved by a man, a permission she certainly did not get from her mother's jealous possessiveness of her father. It was probably received as a communication of my love for and protection of her as well. I wanted her to have a loving internal object, and I conveyed this to her in whatever words I said. This was the root of both the sudden utterance and the hopeful attitude I conveyed. But above all, it conveyed my relief—at least she had someone now who loved her, and I had an ally whom I could hold on to in my mind. That ally, whom I manufactured, made it easier for me to tolerate her pain.

In the session that followed, Anna seemed a shade brighter and talked about her determination to be more sexually responsive to Tom. My sudden words marked another set of links that were hovering at the edge of my unconscious. The patient's associations went from house renovations and Tom to the loved housekeeper—that is, from the possibility of renovations in her analysis to a good object: Tom/housekeeper/analyst.

But allowing herself to move closer toward a new object in her life and in her mind brought anxiety. A few months later, she reported a dream of being flooded by water, "water out of control." Her immediate association was: "Tom and I set a date to be married . . . . Maybe I feel like my feelings will be out of control." Later, she reported having told him that she was used to being alone. "If I weren't coming here, I fear I wouldn't be getting married," she told me. "I feel like the feeling maybe comes out here."

In a subsequent session, Anna reported feeling anxious: "I'm not good about having somebody around. I always said I didn't want to marry anybody I cared about enough so that if that person died, it would be painful. I've been masturbating a lot . . . . I feel dead, still, in the water."

I speculated that Anna's mother had never been with her when she was an infant, so that Anna was never able to take her in as an internal-

ized presence. Perhaps this explained her reference to "dead, still in the water"—that is, *stillborn*, never able to see herself reflected in her mother's face. (This evokes Green's [1998] ideas about the imago of the dead mother in a child's mind.)

In the initial part of the analysis, I needed Tom as an external ally because I felt that Anna had not yet taken me in as a good object, but only as a potentially hurtful and rejecting one, so that her depression seemed dangerous to me. This need for an inner ally was an unconscious one; I was aware only of an uneasiness and puzzlement that centered on trying to make sense of her deep and formless depression.

As the analysis went on, through the differing transferences that took shape, many representations emerged: that of a lost and fleeting mothering object (probably Anna's first nurse); an uncaring and neglectful mother who preferred males; a warm, caring housekeeper; a harsh and unaccepting maternal grandmother who did not like her; and a father. But there was no early sustaining and holding mother from infancy.

In retrospect, I can see my seeking the counsel of a certain male colleague as an expression of my need to find an object situated outside my patient's mind, and even outside the dyad—an object I could take in, lean on, and hold for support. In a totally unconscious identification with Anna, I was looking for a father who could take the place of the absent mother. And it is now clear to me that I was searching for a good object, one that could be counted on and that could provide structure, for both the patient and for me.

CASE 2: DIMITRI

In this case, again, it was the patient's romantic partner who played a dominant role, in both her mind and in mine. I experienced this object differently at different times throughout the treatment, and I would like to explore here what this might mean about the analytic process.

My patient, Helene, a woman in her mid-forties, was in severe crisis when she began seeing me. A few months before, she had discovered that Dimitri, her husband of twelve years, had been having an affair. He blamed her for this, saying that she was too self-assured and not supportive enough of him, and that he wanted a divorce.

She turned for help to her former analyst, Dr. P, and was shocked and dismayed to learn that he had retired. Dr. P called me, explained the situation, and gave me a brief history of his work with Helene and an impression of Dimitri. This particular attention to Dimitri did not strike me as odd at the time, given the situation, but retrospectively, I think it is meaningful. That is, the figure of Dimitri was significant to Dr. P, as it turned out to be for me.

My first impression of Helene was of a tall, stunningly beautiful woman whose presence—even her perfume—filled up the waiting room. But it was clear that she felt totally devastated, abandoned, and betrayed by both Dimitri and Dr. P. Focusing on the present circumstances, she told me that Dimitri, ten years younger than she, had left her for a younger woman, a Russian like himself.

Helene had met Dimitri when he was studying engineering on a student visa, while she was a young business executive. With her business expertise, she had helped him form and run a highly successful company in which they both continued to work—a company based on a sophisticated computer system that he had created. The Pygmalion-like story that she told over the following months portrayed how she had made Dimitri over—from a poor, rough immigrant into a jet-setting executive with expensive tastes. I heard about her own earlier history only later and in isolated fragments.

It was clear that Helene had benefited from her previous treatment and was very attached to Dr. P. She told me that he had helped her learn to trust and to understand the origins of her problems. At first, there were few other people—besides Dimitri, Dr. P, and her animals—whom I heard much about. She had rescued two dogs who had been abused, sheltering them and nursing them back to health and helping them trust human beings again.

Early on, we focused on the patient's angry and disappointed feelings about Dr. P, which clouded her ability to engage with me. In the meantime, Dimitri began having panic attacks and came back to her. They reconciled, but she remained obsessed with his betrayal, suspicious and frightened that he would betray her and leave her again, especially as he continued to blame her for his actions.

Dimitri filled the sessions. Helene recounted his mistreatment of her in many ways. She was jealous of and resentful about the money he had spent with the girlfriend. She talked of his constantly demeaning her by putting her down in front of the employees at work, giving her no credit and claiming her ideas as his own. She described his impulsivity, temper tantrums, demandingness, childishness, and narcissistic rants. She was trying to be submissive to his demands in order to keep the marriage together, and it was striking to note that she could not let herself be angry at him, but instead spoke of how much she was in love with him and how exciting he was to her. The two continued to spend money lavishly, going off on spur-of-the-moment weekend trips to exciting places. She continually asked me to help her understand him: How could he act this way? Was he right? Was she wrong?

A picture of Dimitri formed in my mind: I saw him in a controlling, sadistic position in their sadomasochistic relationship, and Helene in masochistic enthrallment with him. Like Helene, I began to feel that I could not be rid of him. Even though I knew better, in my mind, he took on the enduring role of "the villain of the piece."

A similar metaphor emerged in Helene's first reported dream, from the first month of treatment: "I was in another city and carrying a snake around. I realized it was bent—uncomfortable—I put it in a garage. Tina [a girlfriend] put it in the dishwasher, and it came out like a statue. I was angry, picturing how it had died. Then I was in an airport with Dimitri, with my arm around him. I realized he had lost all his muscles."

Her association went to snakes in the Caribbean, where she frequently traveled with Dimitri. "I often dream of being somewhere else, somewhere foreign. Dimitri has been a snake recently . . . . Boris [a Russian associate of Dimitri's] said something about somebody being a snake in the grass in the business . . . ."

Helene then began to associate to her girlfriend Tina, along with several other women—various friends and a friend's mother—who were "non-nurturing" and not to be trusted. Then she mused, "Dimitri was losing his muscles [in the dream]! I don't know—he's always talking about his muscles. He wants to be admired."

She talked about how Dimitri had told her to dress more conservatively at work because it was hard to concentrate. "I feel he is trying to

dismantle me," she continued, "so that he can stand on his own, shine on his own." She went on for some while in this vein and then said, "I felt drugged yesterday—from sleeping pills and Xanax, perhaps. Like I was going to faint. Why do I feel drugged or poisoned? I don't understand."

I said, "You feel like you're in an altered state of mind."

"Yes, like in a foreign state."

"The dream seems to be saying you are afraid that, with our work here, you will lose the relationship with Dimitri—it has weakened muscles and is losing its strength."

"Yes—plus I don't trust him."

I added, "Like a snake in the grass."

She responded, "Hmm. That's interesting. It's true that Dimitri and I are so intertwined. He's had a breakdown, and then I feel like I have one."

Then came a stream of questions about how to handle Dimitri to keep him from leaving again. I replied that she perceived me as being like the women in the dream—not nurturing, not to be trusted. On the way out, she commented: "I like your dream interpretation."

I would like to be able to say that this comment validated a good interpretation that addressed Helene's initial anxiety about the analysis. In truth, however, I think she was actually thanking me for having positioned Dimitri—and not herself or me—as the snake in the grass. Thus, both she and I could put aside for the time being the anger that I did not think she was ready to manage, letting it be contained in and represented by Dimitri; we could therefore overlook her castrating and erotic impulses evident in the dream imagery: a snake that was put into a dishwasher and became a statue, a snake that died. I focused on what I understood of the dream—her mistrust of me and what the analysis might bring, perhaps the dissolution of her needed sadomasochistic relationship with Dimitri—but I found the rest of the dream confusing.

At this time in the treatment, I felt it necessary to underscore his cruelty and un-dependability (and not mine), and to agree with her that he seemed unstable. In fact, Helene's barrages about Dimitri totally dominated the content of the sessions. I think that in this way, just as Helene felt dominated or let herself be dominated by Dimitri, I felt dominated by him, too. She could not get him out of her head, and neither could

I. I speculate that focusing on him as victimizer helped me get out from under this sense of domination.

Moreover, there was an Alice-in-Wonderland quality to the patient's world with Dimitri, and my principal focus was to try to engage her and help both of us *think* in the face of its seductions and confusions. Thus, at this point, I was dealing with Dimitri as an object and with an object relationship (a sadomasochistic one) that I felt Helene needed to "see" and understand more clearly. At the same time, he became for me a "real" object outside the analytic relationship, rationalized from the viewpoint (and my background) of ego psychology in terms of adaptations to the outer world and ego strengths, such as reality testing. I thought she needed to see that she was being controlled by him. Here my unconscious identification in the countertransference lay with her as a victim controlled by a sadistic object.

As Helene told me stories of particularly abusive (I thought) interchanges between her and Dimitri, it was clear that she would become confused, not trust her perceptions or judgment, and then take in the blame he seemed to be putting on her. For example, when something would go wrong at the business, Helene would try to get answers from Dimitri, who she felt would try to shut her out from important meetings. Giving her incomplete figures that did not make sense to her, he would then call her stupid for not understanding and blame her for the current work troubles. She would then become confused and begin to doubt herself.

At one point in the first year of the analysis, I used the term *gaslighting* to describe such interchanges with Dimitri. Calef and Weinshel (1981) described the phenomenon of gaslighting in terms of the back-and-forth processes of introjection and projection that occur in sadomasochistic interactions. The victims in these interchanges "struggle with the feeling that their minds are being 'worked over,' their thoughts influenced, and the validity of their perceptions undermined. Meanwhile the victimizers perpetrate these distortions, disavowing them and even claiming that they themselves are the victims" (p. 46).

That struck Helene; shortly afterward, she bought a book about gaslighting and watched the classic movie of that name. I told her that she wanted me to help her figure out Dimitri and the world around her, a

confusing world that I thought she must have experienced as a child. For the first time, she began to fill me in about her background, through a series of memories of painful, crazy-making incidents with both parents, which certainly amounted to gaslighting. They labeled their self-serving, sadistic, or neglectful behavior as having been done for the patient's own good, and any distress about it was her fault.

For example, Helene told me that, as a teenager, she was unexpectedly invited by her mother to take a special trip to a Caribbean island. On the first night after their arrival, Helene found herself locked out of their rented condo for hours; it turned out that her mother was entertaining a lover whom she had apparently planned to meet up with on the island. When Helene complained the next morning, her mother blamed her for being ungrateful and selfish.

Helene told me that her mother had been very young, just eighteen, when Helene was born, and she resented her daughter for ruining a hoped-for modeling career. The patient described her mother as competitive and completely self-absorbed, never thinking of or caring for her, and said that her mother often abandoned her to the care of her harsh, Old-World paternal grandmother. Her father was more engaged, but also narcissistic, erratic, and explosive, attacking her verbally when things went wrong with the mother. Her parents divorced when Helene was in her teens. Finally, Helene refused to see her mother again, after repeated incidents in which the patient felt totally and painfully let down by the mother's gaslighting of her.

In these early months, I felt that Helene kept a certain distance from me. As she reiterated her feelings of distrust of Dimitri, I began to point out the parallels between her feelings toward him and her feelings toward me in the transference. She admitted to not wanting to trust me or anyone, ever again. In the first months, I struggled with the feeling that the patient would leave the treatment, would abandon *me*. And indeed, after every major separation, she would announce she was quitting. She frequently went away on weekends and was cavalier about informing me that she would miss appointments.

As we explored this behavior, the patient revealed her conviction that I did not think about or remember her at all, that she simply did not exist in my mind when we were apart. The acting out diminished

after I interpreted that she wanted me to be the one who worried about being forgotten. Later, we got to her terror that she, being left alone, would disappear or cease to exist. Helene's responses to separations and my corresponding countertransference of feeling abandoned suggested a deeply troubled and shaky attachment to the early maternal object, mirrored in her clinging relationship to Dimitri. Gabbard (2012) articulated how sadomasochistic configurations can function to bind and cover early trauma and narcissistic problems of loss and attachment; Helene's conflicted attachment to Dimitri clearly served such functions.

Gradually, Helene began to separate herself from Dimitri's grip, both internally and externally. They lived separately during the work week and got together on weekends. She decided to disengage from their company—even though she feared Dimitri was driving it into the ground—in order to help the marriage, and because she felt her attempts to co-run it were becoming increasingly futile and damaging. As a result of these changes, Helene became less anxious but more visibly sad. As she made these moves, I felt relieved. At that point, I felt that progress in the treatment depended on both of us getting a perspective on Dimitri, as well as on her psychic use of him (note that I am saying *her* psychic use of him, not mine).

But the preoccupation with Dimitri continued. I felt somewhat freed from him, however, and a little more able to be heard by the patient, especially in relation to the transference. She announced that she *did* trust me, but not the process—"look what a mess I still am!" The transference, split in this way, reflected split-off aggressive fantasies, still embodied—in both our minds, to varying degrees—in Dimitri.

Two years into the treatment, catastrophe struck again. First, one of Helene's beloved dogs died suddenly. During this period of grieving, she brought the other dog directly into the session so I could meet him—a concrete manifestation of the patient's objects entering the analyst's space. The way I understand this is that Helene's inner world of objects was so shaken and shaky that she had to bring her remaining dog to me so that *I* could experience and verify the reality of its existence. Castelnuovo-Tedesco (1978) suggested that this need to find external validation for internal objects may be especially pressing during times of loss and mourning.

Second, Dimitri took a long trip home to Russia without her, ostensibly to explore his roots. When he returned, he subjected her to self-absorbed rants about his discoveries for hours, according to her account; she finally became fed up and angry. Then one Monday morning, I received a terse voicemail message from Helene who, to my surprise, was in California. In a cold, caustic voice, she said, "Thanks for all your help," and told me that she was not returning to treatment—or even to the state—ever. She meant never to return.

I felt blindsided, but the next day another call came. Dimitri had again asked for a divorce. Helene was in a panic, and she wanted to talk to me. We set up frequent sessions by phone until she could return home and until I got back from a trip away—a period of about three weeks.

The next two months were very difficult. When Helene returned in person, she seemed to be unraveling. Always carefully dressed before, she now appeared unkempt, distraught, lost. She pasted on a desperate smile at the beginning and end of the sessions. I was concerned about her psychic cohesiveness and the depth of her depression as she described her terror of emptiness and total abandonment.

I had long suspected that Helene abused alcohol; now she admitted to drinking to anesthetize herself to emotional pain. Session after session of Dimitri ensued: a constant, pain-filled barrage delivered tearfully and apologetically—did I think he was really leaving this time; how could he not be thinking of her and suffering as she was; how could this be, etc., etc. It was very hard to keep from answering these queries; the impulse was to soothe a suffering and crying infant.

At this point, Dimitri was no longer in my mind as he had been before. That image—the bad object—seemed to have dissolved, replaced by my clinical concerns and my need to understand this obsessive and desperate lament centered around him.

At first, I told Helene that she wished me to be all-knowing and was enraged at me that I had not been able to prevent this from happening—hence the call from California. I said that she used this obsessive and repetitive litany to keep Dimitri within her and to avoid the terror of her inner world (and herself) dissolving. That is, I thought that Helene's ongoing complaints about Dimitri were serving as a tran-

sitional object—they were soothing, if painful. I was no longer thinking about Dimitri as I had before. *Did Dimitri disappear from my consciousness because of my growing and fuller understanding of the uses to which the patient's object was being put?*

Helene said, "I know what this is about: my mother and my early experiences with her. But how come nothing you say or that anyone says goes in? [She was also barraging friends with the same questions.] How come I don't change?" I felt, actually, that she *was* letting in some of my words—as evidenced, for example, by the very fact that she could step back from her constant lament to ask this question.

Eventually, the patient began to come out of this stage and her perspective widened. In one session, she described feeling disoriented and afraid: "I need to hurry up and get happy. Without these business problems, my life would be emptier. It isn't good to be clinging to a bomb. The business is a monkey on my back, yet as much as it is a pain, it is a connection to Dimitri. I wonder why he couldn't put his otherness [that is, all the failings he disowned in himself] into someone else and not me—I get it all." She revealed that, three days before Dimitri told her he wanted a divorce, she herself had said, "I can't do it any more."

In another session, Helene tearfully complained about having been to an ear doctor, saying that he had hurt her and made her cry; she did not want him to drain her ear and hurt her even more. I interpreted the obvious parallel to me and to the painful analytic process.

She then began to obsess about Dimitri again and invited me to speculate on how Dimitri might be feeling. I said, "You need concrete evidence that you are in his mind and my mind, too. You want me to reassure you and make the pain go away." I felt that the patient had difficulty tolerating strong affects.

A week later, she came to a session a few minutes late. "I was frozen out of my car. Had a bad night. Nightmares. Woke up anxious. Took three-fourths of a Xanax and it knocked me out. It all stemmed from an e-mail to Dimitri about needing a conference call about several important business issues. It was businesslike but not stroking his ego. The automatic reply kicked in that he was out of the office—I imagine he is on vacation with a woman. And I see there were several unusual withdrawals

of $500 on the wrong slips and scribbled, as if he is losing it. It all made me feel so bad."

I asked about the nightmares. "Okay, but first I want to tell you one more thing that happened." She then recounted that she had met a man whom she liked. She felt that he was coming on too strong, however, and she told him she was not feeling well and not ready for a close, one-to-one relationship yet. He texted her saying that she should just be straight and tell him she was not interested. She felt bad about this. (Here is an example of Helene's being in the position of doing the rejecting, of being the one in control.)

"So my dream—I lost my wallet, like what happened last summer on vacation [when she had had a miserable time with Dimitri, gotten drunk and sick and lost her wallet]. And lost my cell phone. The person who was supposed to call wasn't calling. I guess that is Dimitri, or my father [or, as I think now, she was the person who did not call the man who was interested in her, and who often did not call me when she missed an appointment]. Then I was losing my animals—couldn't keep track of them. I was in my house, and a friend, a realtor, was there. All my stuff was there. People who had bought the house had abandoned it. A new realtor said the sale didn't go thorough . . . . Animal food was there. Long abandoned." There was a pause as she silently cried.

"I was trying to pick up some of my things and then went somewhere with Sally, my cousin," Helene said, continuing her narrative of the dream. "We were sitting watching TV in a place like the one we rented when we went to California last month. In reality, it was like being in a tomb because the windows were all taped up—horrible. Then, sitting on a couch waiting for a car. It was not coming, not coming. Then we were driving a car, going around a cul-de-sac, and I was saying to myself, 'Put on the brakes.'" She paused. "Then Sally was moving away. I'm thinking, 'Don't go.'"

Then the patient said, "I woke up thinking I miss Dimitri so. I don't want the relationship to be over. Is this all real? Lots of times in the past, I would wake up and think, 'Did this really happen?' Like with my dog. And then I'd realize, 'Oh, my God—he's dead.' Readjusting to reality. In the time after Dimitri's betrayal, I'd wake up a lot. Had this kind of dreams and then I'd assess the reality. Lots of times it was, 'Oh, yes,

thank God, he's here,' but then sometimes I'd think there's a problem and I'd say, 'I have to fix it.' Like with this guy yesterday—I felt I had to contact him and tell him I was sorry."

"I always have this recurring dream," Helene went on. "Like the kind of dream in which you've missed a class, you know? I've forgotten my animals are still alive. Horrified I've been neglectful. Like the house in the dream, which I dream about a lot . . ."

I said, "The dogs in your dreams represent you. You've been afraid that you would be forgotten and go unattended by me, as you feel Dimitri and your mother have forgotten you."

The patient cried, and there was a long silence. Then she said: "Yes . . . . Lots of times I don't respond, but I heard everything you said and I think it's true. You are right that the animals are me. I don't want to abandon my children, like my mother did. Therefore I'm overly involved [referring to her animals]."

"And I do feel like I'm living in an abandoned, ghostlike place that used to be my life," she continued. "I'm sitting there saying he's gone. I want him to be frozen [that is, frozen in place]. I can't bear the fact that he's with someone else. So if I get little pieces of info—like he's taken money he shouldn't have from our account—it's like unrequited love. I feel like I have no right to feel sorry for myself. I have the world in front of me. What's wrong with me?"

I answered, "You have been in a place like purgatory—clinging to Dimitri in order not to feel empty and dead inside, but afraid to move on. Like this morning, when you were frozen out of moving—forward—to be with me."

At this point, I was dimly aware of feeling more positive and sympathetic toward Dimitri. Then, after this session, I had a dream in which an unknown but attractive man asked me to take care of and feed his baby by a previous wife. He paid off some money to the Russian mafia. In the dream, which was pleasant, there seemed to be a sense of openness.

When I awoke, I thought that the man seemed to be a combination of three people: the actor George Clooney, whom I find rakish and good-looking; a family friend who had shown himself to be untrustworthy; and Dimitri. As I reflected on the dream, I asked myself whether my patient's object had found particularly fertile ground on which to form a negative

image in my mind because of my experiences with my family friend—and, second, whether the sense of openness in the dream had to do with my sense of there being some new breathing and thinking room in the analytic situation as the patient's attachment to Dimitri changed.

My dream seemed to anticipate the emergence of the paternal aspects of Helene's attraction to Dimitri and, optimistically, a more triadic picture or space (Britton 1989). Indeed, in the months that followed, the patient began to talk about her father and her current relationship with him, and about her relationships with other family members and friends about whom I had heard almost nothing before.

Helene also announced that now she wanted to get to her anger at her mother. The dream began to undo our mutually created defense: Dimitri, no longer all bad guy and now an oedipal object whose allure I could understand, cheerfully moved out of the way and asked me to take care of his baby, the patient. As for the pay-off of money in my dream, I wonder if a silent countertransference had been building up throughout the treatment—a sense of being drained by Helene's constant preoccupation with Dimitri, and thus my being *owed* something. I could now put myself in Dimitri's shoes as the object of Helene's attempts at control.

I have tried to demonstrate how the object of Dimitri entered my mind and assumed different visages through a changing set of identifications and counteridentifications (Racker 1957). I think I needed to construct an image of Dimitri to help me handle shared uncomfortable affects in the dyad of Helene and me: anger, confusion, and helplessness.

Finally, a word about the name *Dimitri,* which of course I chose to disguise the real person. I realized as I wrote this paper why I had picked that name. A few months before, I had reread (probably not by accident) a classic suspense novel, a tale of espionage and assignation. The narrative traces the trail of a murdered man through Eastern Europe—a mysterious man, notorious and sinister, yet intriguing. The name of the novel, by Eric Ambler, is *A Coffin for Dimitrios.*

DISCUSSION

In both these cases, in different ways, I became caught up with a person in my patient's life—or, more accurately, with the patient's internal ob-

ject representations of that person, present or absent, in her mind. In both cases, the patient's sense of attachment to her inner objects was shaky.

In the case of Anna, the seeming absence of an internal good maternal object was very troubling to me. This lack of internal structure is always a matter for serious consideration in terms of evaluating the patient's psyche and understanding his or her problems, and may or may not figure in a decision to offer an analysis to that individual. In this case, however, it was much more than an intellectual matter for me. As I have attempted to demonstrate, this absence resonated internally and unconsciously within me to produce a wordless apprehension. Had I been totally overtaken by this fear, I could easily have pulled away from a deeper involvement with the patient by keeping her in psychotherapy at once or twice a week, or by drawing away from her in other ways.

L. Ehrlich (2004, 2010) discussed the importance of unconscious fears and inhibitions within the psychoanalyst that keep him or her from recommending and/or deepening an analysis. She suggests three major considerations in the analyst's reluctance to begin a new analysis: a defense against powerful affects, a co-created resistance, and a manifestation of the analyst's own conflicts. Undoubtedly, Anna was a case in point and an example of all these factors.

With Anna, it was only with my sudden awareness that her boyfriend loved her and my voicing this thought aloud that I became aware of my unconscious fears of deepening the analysis and my identification with the patient's terrified sense of aloneness. Her telling the details of what her boyfriend had said and how he had conducted himself supplied me with some data about him. I used these details to create an inner representation of an object that I thought she needed, and certainly that *I* needed, in order for me to proceed more comfortably in the initial stages of this analysis. At the time, I was not able to become aware of or to make use of other important meanings of this internal event—the maternal role that I had stepped into of reversing the mother's possessiveness in relation to the father, a role that allowed for a more developed and triangular dynamic, and one that included giving Anna permission to be loved.

In the second case, Helene's incessant preoccupation with her bad object drummed him into my mind. My experience of Dimitri as a bad and obstructing object became fixed and interfered with my ability to understand what was going on in her mind and between us in the transference. At first, like her, I was confused and unable to think about the role that he played in her mind. My efforts to help Helene understand that Dimitri was like her parents, consistently gaslighting her, and that she was therefore putting herself in a position to be abused, were helpful, but only up to a point. I was working with the general idea that the people in the patient's life are transference figures, just as the analyst is. I agree with Castelnuovo-Tedesco (1978), who writes: "Characteristic of transference is the *intensity* of the universal need to rediscover in the therapist (and in other current objects) the objects of early childhood" (p. 23, italics in original). It was only when I came to see the defensive use to which both Helene and I were putting Dimitri that a deeper understanding of the transference and the countertransference was achieved.

My experience of Dimitri as a bad object, *my* bad object, made me unable to understand any hostility that might be arising in the therapeutic dyad and the control the patient exerted over me. Thus, I was a key participant in an ongoing resistance (Boesky 1990). This enabled the patient to split off her aggression defensively and to disown it, both of us keeping it out of the analytic dyad. As my bad object, then, Dimitri functioned to help me deal with my discomfort in the dyad. It was the object's fixity in my mind that was the problem, or, to put it differently, it was its quality of being "a dense object"—one with a thickness made up of multiple meanings that collapse into a singular, fixating meaning (Emery 1992)—that made for a sustained blindness.

Ferro's (1992, 1993) metaphor of the analytic enterprise as a narration written by the patient and read by the analyst is useful in thinking about these experiences, up to a point. The metaphor captures the idea that my internal images of Tom and Dimitri were co-creations. Anna and Helene were the original authors who portrayed their inner objects to me, and I, as the reader, elaborated them in my mind. But unlike those of a finished novel, the analytic plot and its characters change as they

go along, edited and rewritten by both patient and analyst, who exert mutual influences on each other.[2]

With Anna, my sense of Tom as a loving person and my communicating this to her allowed her to see him differently and to open herself up more to him. Similarly, as my understanding of my defensive use of Dimitri changed, so did my initial sense of him as villain; thus, I was better able to help Helene break free from the role of victim that she had assumed in her mind and in her life.

I am emphasizing here how much the characters of Tom and Dimitri were fashioned within my imagination. I needed these images to help me manage my countertransference—the discomfort within the dyadic situation that was becoming unbearable. In Anna's case, I needed a new object in my mind that seemingly did not exist in hers; in Helene's, I needed to share a bad object with her and then to create my own version of that object, which helped me find a more hopeful and optimistic sense of future change.

I suggest that this experience of the analyst's temporarily borrowing or reshaping the patient's objects to create a new version for the analyst may not be unique, but to my knowledge it has not been described elsewhere in the analytic literature. With these two patients, I created or partially created an object to help me cope with troubling feelings that arose in the analytic dyad.[3]

I would like to emphasize that the uses of the patient's objects in the countertransference may be particularly hard to detect, as first suggested by Jacobs (1983). This is perhaps because the objects in a patient's story can become real to us as analysts. They take on a distinct gestalt, which forecloses their being scrutinized.

No one's object representations can be understood as directly synonymous with outer reality or with the real people whom we are told about. We know this from Freud (1917), who described the creation

[2] Fundamentally, of course, Ferro (1993) conceptualizes psychoanalytic treatment as a bipersonal field that comprises ever-changing dynamic processes.

[3] This idea may have some overlap with the various concepts of the analytic third. As a concept, the third, while used widely by most contemporary psychoanalytic theoretical traditions, remains ill-defined and is used inconsistently, often even within a particular school. There are many usages of the term, and several attempts have been made to classify these (Aron 2006; Muller 1999).

of an inner world, an ego and superego, from internalizations of lost objects. We also know it from Klein (1940), who gave us a view of the complex introjections/projections and reintrojections that make up the internal world of object relations.

Strictly and ideally speaking, therefore, we know that the pictures our patients give us about the people in their lives are distorted. We are trained to treat these objects as our patients' creations, which emerge from a long and complex developmental process.[4] We are encouraged to understand these figures as pieces of the patient, just as we perceive the figures in their dreams. We listen to them as derivatives that carry the patent's feelings about us and give us pictures of the transference; that is, they open a deeper understanding of the patient's mind for us. But we are not so familiar with the notion that they are *our* creations as well.

While there is a legitimate place for discussion about adaptation to reality (and thus about external object relations and interpersonal conflicts), we would all agree that there are dangers for the analyst in becoming caught up in the patient's life in these ways—that is, in ways that involve accepting the patient's accounts as veridical. Jacobs (1983) and F. Ehrlich (1999), for example, describe the analyst's countertransference distortions about the people in the patient's life. F. Ehrlich became more acutely aware of such distortions in himself through his work with families and couples, in which he saw patients' children, spouses, or parents in person.

The contemporary emphasis on the here and now in the transference steels the analyst against the sorts of enactments and dilemmas I have described here. Yet there are other inevitable pulls in the opposite direction—to become enmeshed in the patient's life, in the stories and memories the patient shares in analysis. As we listen empathically, we are pulled by our identifications with the patient and the characters he or she introduces to us—that is, by countertransferences, whether concordant or complementary, as Racker (1957) delineated.

These two types of countertransferences—identification with an aspect or feeling of one's self with a concordant feeling in the patient,

[4] Increasingly, analysts have come to understand that the infant's early internal world is structured by the mother and other caretakers, and that internal representations of others emerge from interactive, affective-laden experiences (Stern 1995).

or the unconscious taking on of a role complementary to a transferential figure in the patient's mind—were interwoven throughout both the analytic processes described in this article's clinical vignettes. But what I am specifically talking about here are countertransferences that become personified and organized in the analyst's mind around a figure borrowed from the patient's narratives. As I have attempted to demonstrate, we can too easily overlook or become oblivious to our role in shaping our own inner versions of these objects and what they might mean.

While both these cases are dramatic in different ways, such intrusions of, or preoccupations with, a patient's objects are common occurrences for analysts. If unchecked and unacknowledged, they can, as in these cases, hinder and interfere with the analytic process. On the other hand, an awareness of the possible meanings and functions of such preoccupations can help the analyst elucidate important unconscious fantasies and recurrent defensive strategies in the patient, as well as to identify unchecked countertransference reactions in herself.

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625 Purdy Street
Birmingham, MI 48009

e-mail: nkulish@aol.com

Volume LXXXIII, Number 4

WINNICOTT AND HELPLESSNESS: DEVELOPMENTAL THEORY, RELIGION, AND PERSONAL LIFE

BY RYAN LAMOTHE

The author examines Winnicott's theory of development from the perspective of existential helplessness, arguing that (a) his views illuminate healthy (and unhealthy) aspects of religion, and (b) express his stance toward the helplessness of dying and death. The author contends that Winnicott understood the infant's psychic growth in relation to the reality of existential helplessness and absolute dependency. Four interrelated, dynamic paradoxes embedded in Winnicott's developmental perspective are discussed, and these paradoxes are seen as frameworks to depict his notions of ego, transitional objects, and true/false selves. The author posits that religion, which Winnicott included under the rubric of transitional phenomena, can be understood in relation to existential helplessness and can be assessed in terms of the degree to which these paradoxes are dynamic.

Keywords: Winnicott, helplessness, absolute dependency, transitional objects, religion.

> Oh God! May I be alive when I die.
>
> —Winnicott quoted in Kahr 1996, p. 125

> As they came from their mother's womb, so they shall go again, naked as they came; they shall take nothing for their toil, which they may carry away with their hands.
>
> —Ecclesiastes 5.15 (New Revised Standard Version)

Ryan LaMothe is a Professor of Pastoral Counseling at Saint Meinrad Seminary and School of Theology.

In his first interview with Morrie Schwartz, who was suffering from amyotrophic lateral sclerosis (ALS), Ted Koppel asked what Morrie "dread[ed] the most about his slow insidious decay." Morrie responded, "Well, Ted, one day soon, someone's gonna have to wipe my ass" (Albom 1997, p. 22).

This agitated quip is understandable given the looming helplessness and anxiety that would have accompanied not only the inevitability of his death, but also the long process of dying wherein Morrie would lose his independence and physical agency. Later in the book, we discover that Morrie, despite pain and near complete dependency, surrendered to the pleasure of others caressing, massaging, and cleaning his body, calling to mind his dependency and helplessness as an infant. Life, as Morrie and Ecclesiastes reveal, is bookended by these states of existential helplessness and dependency, and in between, existential helplessness remains quietly in the background, perhaps informing and screened by the necessary beliefs (or possibly illusions) in our agency and independence that are embedded in and expressed by our theories, narratives, and rituals.

Psychoanalytic developmental theorists, for good reasons, tend to address only one bookend, namely, infancy and childhood. In general, theorists acknowledge the helplessness and dependency of the infant and explain how the infant develops into an agentic, independent, or differentiated being. These theories or anthropological narratives are not only descriptions of developmental realities, but also expressions of reality. As expressions of reality, developmental theories in part entail authors' conscious and unconscious biases, beliefs, values, and stances toward existential helplessness. A further and underlying notion is that developmental theories themselves are creative social constructions (necessary illusions), emerging from the background reality of existential helplessness.

In this article, I examine Winnicott's theory of development from the perspective of nontraumatic or existential helplessness[1] and argue

[1] It is important to make clear that there are nontraumatic and traumatic forms of helplessness. Nontraumatic forms of helplessness are simply existential realities of human helplessness, such as birth and death. They can be psychologically painful and anxiety evoking, but they are not in and of themselves traumatic (contra Rank 1924). This is not

that (a) his views illuminate healthy (and unhealthy) aspects of religion, and (b) express his stance toward dying and death. More particularly, I contend that Winnicott understood the infant's psychic growth in relation to the reality of existential helplessness and absolute dependency.

In addition, embedded in his developmental perspective are four interrelated, dynamic paradoxes, namely: (1) helplessness in agency and agency in helplessness; (2) integration in unintegration and unintegration in integration; (3) illusion in reality and reality in illusion; and (4) dependency in independence and independence in dependency. These paradoxes, which Winnicott was fond of, serve as frameworks to depict his notions of ego, transitional objects, the sense of going-on-being, and true/false selves.

Given this, I argue that religion, which Winnicott included under the rubric of transitional phenomena, can be understood in relation to existential helplessness, and therefore can be assessed in terms of whether these paradoxes remain dynamic or have collapsed toward one end or the other. Finally, I suggest that Winnicott's theory is itself an expression of his own stance toward existential helplessness, made evident during the last years of his life.

HELPLESSNESS, ABSOLUTE DEPENDENCY, AND EARLY CHILDHOOD

Winnicott's view of helplessness and of absolute dependency—which are related but distinct terms—begins with his theory of childhood development or the maturational process of a child. At birth, Winnicott (1960) argued, the infant is absolutely dependent not only with regard to obvious physical needs, but psychological (or ego) needs as well. "I refer to the actual state of the infant–mother relationship at the beginning," Winnicott (1960) remarked, "when the infant has not separated out a self from the maternal care on which there exists absolute dependence in a psychological sense" (p. 592).

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to say that infancy and death cannot be traumatic, given the right circumstances, such as violent forms of dying or parental abandonment. I add that psychoanalytic therapy is, for the most part, a sociocultural ritual that helps people work through traumatic forms of helplessness.

In terms of the psychological, for Winnicott (1945), the baby has only a very nascent ability to organize experiences, let alone integrate them, and is therefore dependent on the good enough parent's ego and accompanying responses to facilitate the organization of experience. His view of the baby is reminiscent of William James's (1918) comment that, to the baby, the world is "one great blooming, buzzing confusion" (p. 488)—if we understand this blooming, buzzing confusion to represent unintegration, a primary unintegrated state (Winnicott 1945, p. 139).

The child, in other words, is thrust into a world without the necessary cognitive representations to apprehend reality and organize experience, which makes him/her dependent on an attuning or mirroring parent who provides the matrix for the child's emerging ability to integrate experience. To use a Winnicottian metaphor, a good enough parent provides a holding environment, which begins to aid the child's budding ego in organizing and integrating experience amidst this great blooming, buzzing confusion or state of primary unintegration.

Before explaining the parent's function further, I must state clearly and stress that, for Winnicott, this absolutely dependent baby's psychology cannot be understood in isolation from the parent. As Winnicott (1965) is famously noted for saying, "There is no such thing as an infant" (p. 39). Similarly, he remarked, "The other half of the theory of the parent–infant relationship concerns maternal care, that is to say the qualities and changes in the mother that meet the specific and developing needs of the infant towards whom she orientates" (1960, p. 589).

These remarks mean that we cannot comprehend the child's existential helplessness, absolute dependence, and psychological development in isolation from the parent's psychology and his/her interactions with the infant. Thus, the absolutely dependent baby is understood in relation to a good enough parent who demonstrates near-complete adaptation to the infant's needs (Winnicott 1953), suggesting that the child's *state* of helplessness and absolute dependency are inextricably joined with parental responses.

This also means that the baby's nascent ego develops in relation to the maternal ego, which indicates that some part of the baby's nascent ego includes this maternal matrix—patterns of attuning to the infant's assertions that, at the same time, facilitate the child's integration in the

face of unintegration. This developmental description is important when an adult experiences nontraumatic helplessness, because one would hypothesize that remnants of this early relational constellation are present in how the person responds to helplessness and dependency, at least in part. This was likely evident in Morrie's situation and, as seen below, in Winnicott's.

Given this, Winnicott also made an important distinction regarding absolute dependence and helplessness. Winnicott (1975) conjectured that:

> In the memory trace of a normal birth there would be no *sense* of helplessness . . . . I do not believe that the facts justify the theory that in the birth process itself there is essentially a condition in which the infant feels helpless. Very frequently, however, delay produces this very thing, helplessness, or sense of infinite delay. [p. 186, italics added]

Unlike Freud (1926), who posited that an infant *experiences* anxiety related to his/her helplessness, Winnicott believed that a baby who *feels* helpless is already experiencing a failure in the parent's (failure of the environment) ability to adapt to the baby's needs. Winnicott was careful in the selection of his terms. The child is physically and psychically in a *state* of existential helplessness and absolute dependency, meaning that s/he cannot possibly help him-/herself vis-à-vis meeting physical needs or integrating experience; however, s/he does not *feel* helpless or *experience* helplessness unless there is a failure in parental care, prematurely awakening him/her to dependency and helplessness. Hence the child's *state* of absolute dependence corresponds to his/her *state* of helplessness, but not necessarily to a *feeling* of anxious helplessness or some rudimentary awareness of absolute dependence.

There are interesting paradoxes in Winnicott's claims regarding birth, helplessness, dependency, and the ego. "Actual birth," he (1975) wrote, "can easily be felt by the infant, in the normal case, to be a successful outcome of personal effort owing to the more or less accurate timing" (p. 186). Here we see the notion that the infant "believes" s/he participates in birth, implying both the presence of agency (an aspect of the ego) and, perhaps, the first existential illusion—belief in one's agency when one is in fact helpless.

Recall that, for Winnicott (1965), the nascent ego is initially in an unintegrated state, yet this unintegrated state does not mean that the baby is without rudimentary agency or that unintegration is absolute. I understand this in four ways. First, in this early state of helplessness, the infant possesses some agency or necessary belief in agency that is facilitated by good enough parental attunement.[2] In the initial period of life, then, there is agency in this state of existential helplessness and helplessness in agency, in that existential helplessness is part of the background *reality* of the ego.

Second, the infant's belief in his/her "personal effort" (or agency) is an illusion in the midst of the reality of the state of existential helplessness, which points to another initial paradox—illusion in reality and reality in illusion. Third, in this state of unintegration, the belief in his/her personal effort suggests some rudimentary integration, pointing to a third paradox—integration in unintegration and unintegration in integration.

The fourth paradox concerns the relation between absolute dependency and independence. "At the beginning," Winnicott (1965) wrote,

> . . . the infant is entirely dependent on the physical provision of the live mother and her womb or her infant care. But in terms of psychology we have to say that the infant is at one and the same time dependent and independent. It is this paradox that we need to examine. [p. 84]

By this, Winnicott meant that the parent does not create the child as an artist creates a painting or a statue. The child, then, is an individual and ideally a source of his/her own creative expressions instead of an object solely dependent upon the creator. The baby's nascent ego, therefore, emerges within the paradoxical tension of absolute dependency

[2] Winnicott, of course, is speculating about the internal life of the infant. That said, there is something true about possessing a necessary belief in our agency when facing the reality of existential helplessness. As adults, we do have agency, but it seems to me that this is a mix of reality and illusion. We go about obtaining an education, getting married, raising children, believing we are cooperating with life, and that we will live to realize our projects. This is all very agentic and necessarily so, yet it takes place against the background of the reality of death, against which we are helpless. In other words, our belief in and experience of agency takes place in the context of the reality of the helplessness vis-à-vis death, which means that there is existential helplessness embedded in agency.

and independence—there is independence in absolute dependency and absolute dependency in independence.

Let me return to the parent's role vis-à-vis the baby's absolute dependence to further unpack Winnicott's relational understanding of helplessness vis-à-vis the maturational process in early infancy and the presence of these paradoxes. A good enough parent's near-100% adaptation to "the infant's maturational processes is a highly complex thing, one that makes tremendous demands on the parents" (1965, p. 85). This initial adaptation involves "maternal preoccupation," which is manifested in the good enough parent's close attunement to the infant's assertions. This provides the infant with an experience of and belief in his/her omnipotence (Winnicott 1971), which are crucial for the emergence of the child's ego—the capacity to integrate—and the emergence of a true self.

Winnicott (1965) remarked that the "beginning of ego emergence entails at first an almost absolute dependence on the supportive ego of the mother-figure and on her carefully graduated failure of adaptation" (p. 9), wherein the child is eventually weaned from this illusion of omnipotence, transferring it to a god object or some other cultural object.

From a different angle, Milner (1969) wrote:

> In fact I was coming to think more and more about an infant's primary need for the illusion of omnipotence, made possible through the mother's adaptation, if the necessary disillusion and recognition of helplessness is to become a creative reality. [p. 107]

Before moving to the issue of disillusionment, I will note that the main point here is that the experience of and belief in omnipotence enables the child to have an experience of confidence with which to begin creatively constructing and integrating his/her own experience—*primary creativity* (Winnicott 1953). Another important distinction is that the *belief* in omnipotence is a necessary illusion, while the *experience* of confidence is real because of the parent's near-complete adaptation to the baby's assertions. So, while the child is absolutely dependent and helpless—in reality—in fantasy, s/he is also omnipotent. For instance, s/he becomes hungry and the breast magically appears, which suggests a rudimentary confidence in his/her ability to organize experience.

The parent's near-100% adaptation, then, shields the baby from experiencing anxiety associated with the consciousness of his/her existential helplessness. At the same time, it gives the child a necessary experience of and belief in omnipotence. The inner reality vis-à-vis the illusion of omnipotence, then, is the baby's confidence in the face of the existential state of helplessness and unintegration, and it is this confidence that becomes part of the true self—signifying rudimentary integration.

So far, we see in Winnicott's (1965) theory that the child needs the help of the maternally preoccupied parent for integration of his/her experiences and for the illusion of omnipotence, which are necessary for ego development (p. 9). Two other key features of this stage of development related to helplessness are a "non-purposive" (1971, p. 55) state and rest. The baby's state of absolute dependence and the parent's near-100% adaptation to his/her needs make possible the child's sense of "going-on-being" (1960, p. 587) or non-purposive being. This indicates that this early stage of unintegration or formlessness is not anxiety provoking or disturbing, but rather tolerable and perhaps even pleasurable (Morrie's helplessness, for instance), which implies *an early organization of experience vis-à-vis the state of unintegration and existential helplessness.*

Consider Winnicott's (1958) remark that the

> . . . infant is able to become unintegrated, to flounder, to be in a state in which there is no orientation, to be able to exist for a time without being either a reactor to an external impingement or an active person with a direction of interest or movement. [p. 418]

Later, Winnicott (1971) wrote:

> I find that it is here, in the absolute dependence on maternal provision of that special quality by which the mother meets or fails to meet the earliest functioning of the female element, that we may seek the foundation for the *experience* of being. [p. 84, italics added]

If we can leave aside the problematic assignment of gender to being, Winnicott was arguing that in this early state of unintegration, the baby, given the good enough parent's attunement, experiences a sense of

going-on-being—a sense of continuity and being at rest in the midst of buzzing chaos or state of primary unintegration. Thus, the parent's maternal preoccupation allows the child to experience quiescence or rest, and ideally the baby is relatively free of anxiety in this state of unintegration, helplessness, and dependency.

This ability to contain and handle unintegration and to experience rest becomes, for Winnicott, a crucial feature of psychological development and the concomitant capacity for creativity and experiences of being alive in childhood and, later, in adult life. In brief, the absolutely dependent infant is helpless with regard to integrating experience and meeting his/her own psyche-soma needs, but s/he does not experience this helplessness in terms of anxiety when engaged with a good enough parent (1975, p. 186). Rather, if all goes well enough, the baby is able to experience a sense of going-on-being and rest in the midst of this formlessness or unintegration, which is essential for primary creativity, as well as for creativity and aliveness in adult living—the development of a true self.

By contrast, parental impingement and deprivation result in the infant becoming relatively conscious of his/her dependence and helplessness, which in turn heightens anxiety and shatters both the illusion of omnipotence and the experience of confidence, leading to diminished ego development and the loss of experiences of being alive. Put another way, parental failures that are not repaired initiate the development of a false self, and suppress freedom and creativity (Winnicott 1955). All this suggests that, if all goes well enough between parent and infant, the paradoxes remain dynamic. And if there are unrepaired parental failures, paradoxical tensions collapse toward one pole or the other (e.g., fantasy split off from reality).

Of course, Winnicott (1967) recognized that maternally preoccupied parents cannot be completely adapted to the infant. There are always disruptions in care, which are crucial in psychosocial development. "Babies," Winnicott observed,

> . . . are constantly being cured by the mother's *localized spoiling* that mends the ego structure. This mending of the ego structure re-establishes the baby's capacity to use a symbol of union; the

> baby then comes once more to allow and to benefit from separation. [p. 369, italics added]

When there is a disruption in the parent's ministrations, the baby's assertion vis-à-vis his/her need (physical and psychological) is not recognized or met. This momentary deprivation heightens the baby's anxiety, moving him/her closer to an awareness of helplessness and absolute dependence, as well as *nonbeing* (the loss of experience of "non-purposive" being [Winnicott 1971, p. 55]). Another way of saying this is that the baby, in this moment of deprivation, is on the cusp of realizing that s/he is not omnipotent, which would be a blow to his/her nascent ego. In a good enough situation, the parent recognizes the disruption and repairs the relationship and thereby the nascent ego. This restores the baby's confidence in the environment (basic trust) and in his/her omnipotence relative to organizing experience. The baby then obtains an experience and belief that disruptions and momentary helplessness are tolerable; that is, there is hope in the midst of helplessness—hope of the other's helpful response.

To sum up, during this first stage of the maturational process, the infant is in a state of absolute helplessness and dependency, relying on the parent to meet physical and ego needs. The parent's near-100% adaptation to the infant enables him/her to obtain an experience of and illusion of omnipotence, which is necessary for the development of the nascent ego and its concomitant integration of experience. One way to understand this early period of development is through four Winnicottian paradoxes.

First, the initial ego emerges from and is formed in the midst of the state of helplessness and primary unintegration, which means that there is *existential helplessness in agency and agency in helplessness.* Second, there is an initial illusion of agency (cooperating in the birth process), given the reality of unintegration and existential helplessness, meaning that there is *reality in illusion and illusion in reality vis-à-vis the nascent ego.* Third, the baby's ego rudimentarily organizes experience in this state of unintegration, pointing to the third paradox of *integration in unintegration and unintegration in integration.*

The final paradox concerns the state of absolute dependency and the child's independence. The child's initial sense of *independence oc-*

curs in the reality of existential dependency. If these paradoxes remain dynamic through the care of the good enough parent, then the infant is able to obtain a sense of going-on-being or rest in the midst of primary unintegration and the *state* of helplessness. In addition, the child is able to experience a sense of creativity and aliveness, the first building blocks of the emergence of a true self. Stated negatively, impingement or deprivation collapses the dynamic tension between one pole or the other, leaving the infant with heightened anxiety in the face of the reality of existential helplessness, a loss of the illusion of omnipotence, the forfeiture of experiences of aliveness, and the defensive organization of a false self.

Naturally, the state of absolute dependence and maternal preoccupation lasts only a few months. Relative dependence is the next stage, and this occurs as the parent naturally directs his/her attention to other matters, which initiates a period of titrated disillusionment with respect to the infant's experiences of omnipotence. Winnicott (1953) argued that "the mother's main task (next to providing opportunity for illusion) is disillusionment. This is preliminary to the task of weaning, and it also continues as one of the tasks of parents and educators" (p. 95).

Disillusionment is necessary for the child to move toward acceptance and use of reality, as well as shared experience (Winnicott 1971). Ideally, disillusionment takes place within the context of a caring and responsive parent, which enables the child to remain connected while separating. What helps the child move to relative dependence in the face of separation and disillusionment is the child's use of transitional phenomena, which empowers the child to abrogate, yet paradoxically retain, both the experience of and belief in omnipotence that were necessary to gain the confidence to organize experience vis-à-vis the transitional object. Here the child, in moving to greater independence, is able to use self-selected objects (transitional objects, representing previous child–parent interactions) to organize and integrate experience, as well as to soothe him-/herself during periods of anxiety associated with separation (Winnicott 1953).

It is important to stress that the transitional object is connected to the child's experience of and belief in omnipotence, even while s/he is being disillusioned. That is, while there is some abrogation of omnipotence during this period, the child continues to believe in and experi-

ence omnipotence vis-à-vis transitional phenomena (Winnicott 1971). I suggest that transitional phenomena, ideally speaking, enable the child to face and handle moments of unintegration in the midst of his/her integrating experience. That is, the child retains the experience of going-on-being in relation to his/her transitional object, and it is this experience of being that s/he can return to for solace during times of separation or distress.

In terms of helplessness, the child may begin to feel anxiety in the face of separation and, before *feeling* helpless, soothe him-/herself by making use of an object that represents previous parent–infant interactions. Furthermore, during this period of relative dependence, Winnicott (1965) argued that:

> The ego changes over from an unintegrated state to a structured integration, and so the infant becomes able to experience anxiety associated with disintegration. The word disintegration begins to have a meaning which it did not possess before ego integration became a fact. In healthy development at this stage the infant retains the capacity for re-experiencing unintegrated states, but this depends on the continuation of reliable maternal care or on the build-up in the infant of memories of maternal care beginning gradually to be perceived as such. The result of healthy progress in the infant's development during this stage is that he attains to what might be called "unit status." The infant becomes a person, an individual in his own right. [p. 44]

There are three important points here. First, the child's ego capacities are growing as s/he increasingly takes over integration of experience and agency vis-à-vis use of objects. With this growth comes the possibility of experiencing disintegration, which is distinct from the earlier period of unintegration that a child is still able to experience because of an attuning, good enough parent. Second, the child is able to handle moments of unintegration (and helplessness) because of his/her use of memories of previous and ongoing reliable parental care associated with experiences of going-on-being or non-purposive rest.

A third point, which is an added claim, is that these paradoxes remain dynamic in development as the child makes use of transitional phenomena. That is, there is (1) agency in helplessness (the child continues

to be helpless, though less so and the reality of existential helplessness remains), (2) reality in illusion (external object under omnipotent control), (3) integration in unintegration (state of primary unintegration is present in the midst of the child's integrating experience), and (4) independence in dependency (the child's growing independence accompanies the reality of his/her dependency and the background reality of existential dependency).

The last stage, much lengthier, is toward independence, wherein the "infant develops means for doing without actual care. This is accomplished through the accumulation of memories of care, the projection of personal needs and the introjection of care details, with the development of confidence in the environment" (Winnicott 1960, p. 591). Confidence in the environment means trust in the sociocultural realm. This trust is accompanied by a move away from transitional objects associated with the stage of relative dependence, as well as a handing over of omnipotence to the larger cultural field.

Recall that in the stage of relative dependence, the child retains the experience of and belief in omnipotence through a transitional object. As the child matures, the transitional object loses meaning and is not mourned, because "transitional phenomena have become diffused, have become spread out over . . . the whole cultural field" (1953, p. 91).

This means that omnipotence is abrogated by handing it over to the larger cultural field, which includes art, science, and religion. Yet it would be more accurate to say that the experience of and belief in omnipotence become the property of the larger sociocultural field, which points again to Winnicott's penchant for paradox. The individual hands over subjective omnipotence, yet partially retains it through his/her participation in the culture—intersubjective omnipotence.

In this stage of independence, an individual learns to care for him-/herself, but this does not mean that adults do not need the care of others. Adults can experience routine helplessness and dependency, requiring the aid of others. From a Winnicottian perspective, an adult's willingness to obtain help, to experience and face some degree of unintegration, and to be appropriately dependent are linked to his/her early experiences of maternal care. In other words, some degree of unintegration,

as well as helplessness, are not defended against, but instead handled and accepted.

So we would expect a relatively healthy adult to be able to handle nontraumatic experiences of helplessness by (1) finding objects of solace (experiences of being or rest), and (2) reaching out for help and in so doing obtaining a sense of relief, solace, and pleasure. By contrast, an individual who has not had those early experiences may respond either by abhorring helplessness and dependence—relying on an overly rigid ego—or collapsing in the face of the very whiff of unintegration—where unintegration is equated with disintegration.

Before moving to Winnicott's view of religion and its relation to helplessness, I wish to suggest that there is something interesting and crucial about Winnicott's understanding of the ego vis-à-vis helplessness. Early in life, the infant's ego leans on and takes in the good enough parent's ego through his/her ministrations, which enables the baby to be at rest in a state of unintegration. This is important because one of the tasks of the ego is to integrate. So now we have an ego that, leaning on the maternal ego, is capable of being at rest in this state of primary unintegration, because s/he has experiences of going-on-being (1960). The paradox is that the nascent ego can be in a state of unintegration while having an experience of going-on-being—suggesting integration in the midst of unintegration and unintegration in the midst of integration. While the move to relative dependence and independence means that the ego becomes more adept at being able to organize experience, periods of unintegration, though fewer, remain important, especially with regard to creativity.

Consider an adult who defends against any experience of unintegration because s/he associates it with disintegration. His/her creativity will be diminished and s/he will feel less alive. Put another way, the false self may be considered a defense against unintegration—perceived as disintegration—signifying an unconscious refusal to accept the contradictions of life. From Winnicott's perspective, the adult's capacity to sink into unintegration, relying on and trusting his/her sense of going-on-being, will lead both to experiences of being alive and to creative living. Here the person accepts the paradoxes without trying to solve them. There is almost a Buddhist-like aspect to this perspective. An adult, to be

creative and more fully alive, taps into his/her state of being at rest, his/her sense of going-on-being, while handling unintegration—unintegration that is critical for creativity.

The ego must let go of the ego qua integrator to be creative, to be alive. The ego, if you will, embraces the state of helplessness, dependency, and unintegration while organizing the experience of being. This perspective becomes crucial when considering Winnicott's appreciation of religion and his stance in the face of the ultimate reality of unintegration—dying and death.

EXISTENTIAL HELPLESSNESS, ILLUSION, AND RELIGION

Religion, I argue, is a case in point regarding Winnicott's view of development in relation to existential helplessness and dependency. More particularly, I take note of Winnicott's view of religion in terms of the four paradoxes evident in this theory, suggesting that healthy expressions of religion are manifested whenever these are dynamic and accepted, while unhealthy use of religious objects reveals the collapse of tension toward one pole or another.

Winnicott did not write a great deal about religion, but it is clear he did not equate religion itself with a defensive illusion or a neurotic response to experiences of existential helplessness. Rather, Winnicott believed that illusion was a necessary feature of creative living, which included religion and other cultural phenomena. Of course, he knew that illusions could be defensive, immature, and destructive.

We note the distinction between healthy and unhealthy illusions in Winnicott's (1953) remark:

> I am therefore studying the substance of illusion, that which is allowed to the infant, and which in adult life is inherent in art and religion, and yet becomes the hallmark of madness when an adult puts too powerful a claim on the credulity of others, forcing them to acknowledge a sharing of illusion that is not their own. [p. 90]

Madness—secular or religious—occurs whenever illusion parades as absolute, universal truth, or when someone has retreated into private illusions to escape the realities of life.

While Winnicott did not view religion simply as a response to developmental helplessness, he understood it in relation to early childhood and the lifelong struggle to differentiate between internal and external reality. "It is assumed here," Winnicott (1953) wrote,

> . . . that the task of reality-acceptance is never completed, that no human being is free from the strain of relating inner and outer reality, and that relief from this strain is provided by an intermediate area of experience which is not challenged (arts, religion, etc.). [p. 94]

The metaphor "intermediate area of experience" refers to the area "between the thumb and the teddy bear, between the oral eroticism and true object-relationship, between primary creative activity and projection of what has already been introjected, between primary unawareness of indebtedness and the acknowledgement of indebtedness" (1953, p. 89). For Winnicott, the intermediate area of experience was not simply inner (subjective creation) or external (shared) reality, but both, and "constitutes the greater part of the infant's experience and throughout life is retained in the intense experiencing that belongs to the arts and to religion and to imaginative living, and to creative scientific work" (p. 97).

For the child and the adult, there is a tension between internal reality (illusions) and external reality. Is this objective reality or is it my creation? Did I discover this or is it my creation? This is an individual and social dilemma, suggesting that the intermediate area of experience is not merely an individual phenomenon, but a social one as well—hence art and religion are individual and social realities. Winnicott believed that religion is, in part, linked to this intermediate area of experience, and that associated religious illusions provide a resting place from the demands of differentiating between internal and external reality.

All this is fine, but we are left with a question about the relation between religion and existential helplessness. If the intermediate area of experience is associated with early childhood and adulthood, then how are we to understand religion vis-à-vis absolute dependency and helplessness? Asked differently, is there a connection between the nascent ego leaning on the maternal ego, unintegration, the original state of helplessness/dependency—and religion? And how can we understand religion in terms of the four paradoxes of early life?

To answer these questions, I reframe Winnicott's notion of religion, if only slightly, to indicate the connection between religion and this early *state* of existential helplessness, absolute dependency, and unintegration.

As indicated earlier, if all goes well enough, the baby will lean on and internalize the maternal ego ministrations, obtaining a sense of going-on-being in the midst of a state of helplessness, absolute dependency, and unintegration. This core or aesthetic experience (Bollas 1992) gets transferred to the transitional object, enabling the child to handle separation and its accompanying anxiety. Later, god representations,[3] which are socially shared reality, can be picked up by a child (and adult) and used to contain what is good about him-/herself (Winnicott 1965), as well as serving as a resting place in moments of unintegration and separation.

In other words, god representations can become linked to a sense of going-on-being, rest, and confidence when faced with unintegration. God representations, then, can be used to provide a sense of going-on-being in the face of the state of helplessness. The *illusion*, from a Winnicottian point of view, is the belief in God, but the *reality* is the person's experience of confidence in a sense of going-on-being—an experience that enables the believer to be in unintegration (mystery) and therefore to use it, if you will, to be creative, to be alive. The experience of being, of being alive, of rest are all inner realities,[4] and this is why illusion or belief in God is not something defensive that inhibits an individual, but rather an illusion that is necessary for his/her creative living.

Healthy religion, then, retains the paradox of reality in illusion and illusion in reality. Unhealthy religion involves a refusal to accept the paradox and is seen in the madness of forcing religious "truths" on others, or the individual or collective escape into a religious fantasy world di-

[3] In using the notion of god representations, I am also including the religious narratives, rituals, and religious social practices in which these god representations are embedded. The narratives and practices can contribute to and represent experiences of going on being in the face of unintegration.

[4] The experience of being alive is an inner reality that is connected to the illusion—belief in God. From a Winnicottian perspective, one can have an experience—inner reality—that is connected to an illusion. I would add that shared experiences of creativity and being alive are external realities in that they are shared and acknowledged collectively. They are, at the same time, connected to a shared illusion—belief in God.

vorced from concrete realities (e.g., religious believers who reject clear scientific evidence of global warming or evolution).

This is a general view of religion or the use of religious objects. It can be helpful to examine briefly specific religious representations in terms of Winnicottian paradoxes and existential helplessness to highlight reality in illusion and illusion in reality. Consider, for example, the Judeo-Christian myth of God's creation of the world and the creation of Adam and Eve from nothingness. Here we clearly have an omnipotent social construction—the story—that represents, in part, an explanation of the founding of creation and human life. The Jew and the Christian believe that God is the agent who omnipotently creates the cosmos from nothingness, meaning human beings are absolutely dependent on God's creative act.

This narrative can be understood in terms of the four Winnicottian paradoxes. First, a healthy use of it is exemplified by the believer who recognizes that the story is a myth that does not represent what actually happened. Yet there is recognition of the existential fact that human beings cannot initiate life from nothingness, and human beings do not control life or death—at least not absolutely. Human beings are, then, existentially helpless and dependent with regard to being theologically understood. This myth, in short, is an illusion that holds an existential truth. An unhealthy use of this narrative is seen when it is taken literally, which represents the collapse of the paradox of illusion in reality and reality in illusion.

The paradoxes of agency in helplessness and absolute dependence and independence are evident as well. In the creation story, the origins of life are located not in human agency but in God, though human beings possess agency that is derivative. We are absolutely dependent on God's agency for our own agency—an agency that expresses a capacity for independence. One can note the parallels between this view and Winnicott's portrayal of infancy. The baby's ego is derivative in the sense of being dependent on the parent, yet there is indeed a nascent ego independent of the parent.

A related religious belief that is connected to this story is *imago dei*—the belief that human beings are created in the image and likeness of God—further illustrating the dynamic features of Winnicott's existential

perspective. We human beings are helpless before God, yet we retain agency in our ability to participate in creation; like God, humans are creators, yet human creations are derivative even as human beings are independent of the creator. The story and attendant belief are themselves expressions of the paradoxes of helplessness in agency and absolute dependence in independence. Human beings omnipotently construct a story that expresses their agency while at the same time handing over the foundation of agency to God. The collapse of these paradoxes is seen in the use of agency to avoid the reality of existential helplessness and dependency (arrogance as an exaggeration of agency) or the avoidance of one's agency and independence (extreme passivity/despair—exaggeration of helplessness).

Ultimately, the paradox of integration in unintegration is present as well. In the myth, God creates *being* from the abyss or out of nothingness. There are two features here. First, the abyss may be said to be a symbol for absolute unintegration, from which God creates integration. The God-self represents being—an integrating/creating being—in the midst of unintegration, and unintegration has no connection to disintegration. Human beings are created out of nothingness or unintegration. If the story is seen not as a *description* of reality but as an *expression* of reality, one notes the Winnicottian paradox of integration in the midst unintegration. Being—integration—rests in relation to unintegration.

Second, God represents a being who can be known but who is also a mystery. That is, the story itself signifies some knowledge of God's creative activity, yet God is mystery. Knowing God represents integration—experiences of God—and mystery represents unknowing or unintegration. Healthy religion embraces the paradox of knowing (integration) in not-knowing (unintegration). A collapse of this paradox is seen when a religious person either makes too great a claim on his/her knowledge of God (rejection of mystery and unintegration) or retreats into absolute mystery or unintegration. Put another way, unhealthy use of religious objects reflects an underlying anxiety relating to unintegration as disintegration vis-à-vis existential helplessness and dependency.

In brief, Winnicott's understanding of the use of religious objects serves as a case in point regarding the four paradoxes in relation to existential helplessness and dependency. Healthy expressions of religion

involve maintaining and embracing the four Winnicottian paradoxes, while unhealthy use is reflected in their collapse toward one pole or the other.

WINNICOTT'S THEORY AS AN EXPRESSION OF REALITY AND EXISTENTIAL HELPLESSNESS

We often think that developmental theories are somehow separate from the lives of the theorists, and in many ways they are. However, psychological theories can also be understood as stemming, in part, from the worldview of the theorist, reflecting and inflecting his/her biases, values, and anxieties. Winnicott's theory of childhood development and its relation to existential helplessness and absolute dependency are not simply descriptions of reality, but expressions of his own understanding of life.

More particularly, I depict Winnicott's confrontation with his own physical decline and impending death from the perspective of the four paradoxes within his theory of childhood development. For Winnicott, these paradoxes had specific relevancies to adulthood (e.g., transitional phenomena). Like religious phenomena, Winnicott's life serves as a case in point, then, for his understanding of existential helplessness vis-à-vis illusion, reality, ego integration, and unintegration, going-on-being, etc.

Winnicott suffered his first heart attack in 1954 and a severe cardiopulmonary crisis in 1968, three years before his death (Rodman 2003). Several years before the cardiac crisis, Winnicott, age sixty-seven, wrote a poem. While this poem concerns his mother, it also points to the intersection of death and aliveness, as well as to the presence of the four paradoxes.

Mother below is weeping
Weeping
Weeping
Thus I knew her
Once, stretched out on her lap
As now on dead tree
I learned to make her smile
To stem her tears
To undo her guilt

To cure her inward death
To enliven her was my living.
[Winnicott quoted in Kahr 1996, p. 10]

Winnicott appears to be simply recalling his childhood, but at the age of sixty-seven, he was already facing death and his own unintegration—curiously motivating him to write a poem about his childhood relationship with his mother. Is this also a poem about being alive and enlivening his self in the face of the end of his life? Is this similar to an illusion or dream (and memory) where his maternal side weeps in the face of life and death, and another side of him provides solace and aliveness in the face of loss? Were his old age and encroaching death stirring up memories of other losses?

Obviously, his poem is overdetermined and, I contend, not simply associated with a memory of his relationship with a depressed mother. On the one hand, the poem represents a child who is helpless before a mother who is lifeless, not responding, and upon whom he is dependent. And yet the child seemingly discovers a way to enliven her, using his agency to bring her out of depression, which has its own form of helplessness. On the other hand, the backdrop to this poem is Winnicott's own aging and encroaching death.

The poem, in other words, also represents an older man facing losses and death, and while he feels sadness and perhaps guilt, there remains a source of psychic aliveness and agency in the midst of facing existential helplessness with respect to death. I suggest, then, that the poem represents a confluence of the existential reality of helplessness and dependency. Childhood memories and emotions were evoked by the impending helplessness and dependency of an older man facing decline and death.[5]

I would add here that the poem is itself a creative response in the face of the existential helplessness of death. This and Winnicott's other poems represent transitional phenomena, reflecting the paradoxes in his theory. Death represents separation, the loss of ego or agency, absolute

[5] Recall Morrie's recollection of childhood helplessness and dependency as he faced the helplessness of dying (Albom 1997).

unintegration,[6] and human helplessness before this existential reality. In facing death, Winnicott turns to poetry—an expression of agency and creativity in the face of the ultimate loss of agency and unintegration. Put another way, Winnicott integrates the experience of separation, loss, and aliveness in the face of his helplessness before the unintegration of dying and death.

There is, then, agency in the midst of helplessness. Moreover, the poem as a creative expression represents the paradox of reality in illusion and illusion in reality. The belief in "curing her inward death" is illusory, signifying a belief in his omnipotence vis-à-vis the dead mother. There is a resurrection theme, if you will, with the child doing the resurrecting—an illusion of agency as well. What is real here, in my view, is the reality of old age and death—existential helplessness. What is also real is the poet's experience of aliveness in the face of death and disconnection. The poem portrays his experience of being alive, and is thus an expression of a true self in the face of existential helplessness.

Another poignant and clear illustration of Winnicott's creativity in relation to dying and death is seen during the last two years of his life. Winnicott knows he is dying, and again he turns to the transitional phenomenon of poetry:

> Let down your tap root
> to the centre of your soul
> Suck up the sap
> from the infinite source
> of your unconscious
> And
> Be evergreen.
>
> [Winnicott quoted in Kahr 1996, p. 123]

In this poem, we note his embrace of unintegration—the infinite source of the unconscious. The "soul," as well, represents something that

[6] One could argue that death represents absolute disintegration, but Winnicott likely thought about death as a state of unintegration. Winnicott (1945) associated the notion of disintegration with a failure during the state of primary unintegration. He wrote, "I will try to explain why disintegration is frightening, while unintegration is not" (p. 140). In brief, disintegration is associated with trauma and fear/anxiety, while unintegration is not. When Winnicott exclaims, "May I be alive when I die" (quoted in Kahr 1996, p. 125), he is, in my view, not associating death with disintegration.

cannot be fully grasped, yet is known. At the same time, it is important to recall the context of the poem—Winnicott's recent, severe cardiac crisis and his advancing age. Stated in a nonpoetic way, Winnicott was using his agency to integrate what cannot be integrated—not-knowing and death.

If we allow for the context, it becomes clear that the poem signifies Winnicott's (1960) enlivening and creative ("evergreen") experience of going-on-being, despite the fact of his impending death. This poem, like the one quoted previously, represents the play of creative illusions ("Let down your tap root") in the midst of real experiences of being alive and at rest in the face of terminal unintegration. In sum, the poem signifies the aliveness of a true self in facing unintegration.

A similar and very telling comment was made in a lecture during the last year of his life. Winnicott told the audience, "A great deal of growing is growing downwards. If I live long enough I hope I may dwindle and become small enough to get through the little hole called dying" (quoted in Kahr 1996, p. 125). Is this not a reversal of his comment about birth?

A nascent ego or agency is involved in the baby's struggles to be birthed into a new reality—one that is initially formless or in a state of unintegration. The baby, while helpless, to a small degree participates in his/her birth—a birth that s/he is unable to integrate. It is this small ego that cooperates in the movement to life outside the womb. Winnicott believed that at the end of life, the ego, which has grown considerably, ideally needs to become smaller so that it can go through the little aperture that leads to formlessness—to the unknown, to unintegration.

Winnicott is saying, I believe, that to embrace the infinite—that which cannot be integrated—the ego must dwindle. One notes as well that this comment and the poems quoted earlier are free of anger, resentment, resignation, or heroic fighting in the face of dying and death, reflecting the collapse of the paradox toward agency and a rejection of helplessness. The absence of fighting or strident agency does not connote passivity, which would be a collapse of the paradox toward absolute helplessness and the absence of agency; instead, Winnicott manifests an active, creative participation in the face of the ultimate formlessness—the reality of death.

In other words, his participation is a paradoxical act toward making the ego smaller—agency—in the face of helplessness and absolute de-

pendency. In terms of helplessness, Winnicott can do nothing about the reality of his dying and his eventual death, except to be creative and participate in the dwindling of his ego. Perhaps the illusion is that one can indeed make one's ego small enough to fit through the tiny hole of death.

Another important example of Winnicott's attitude and experience of helplessness is seen in a religious comment he made toward the end of his life. In his unfinished autobiography, he wrote a prayer: "Oh God! May I be alive when I die" (quoted in Kahr 1996, p. 125). First of all, note that Winnicott's prayer is not for eternal life. There is no illusory belief about eternal life when facing the reality of death, yet there is an illusory belief in the object of his prayer—a transitional object.

Further, the petition reflects Winnicott's helplessness—something over which he has no control—and absolute dependency. And yet the prayer represents the ego integrating experience in the face not of primary unintegration, but of terminal unintegration. I add that embedded in this prayer is a sense of going-on-being—a hope and confidence in experiences of going-on-being and of aliveness (but not a certainty of them) in the face of helplessness and unintegration.

This prayer must also be seen in light of its composition in the last year or so of Winnicott's life. During his final eighteen months, he made a point of saying goodbye to friends and colleagues, even as he continued to work.

All this points to a man who embraces the great unintegrating realities of human life—dying and death—while still being creative and alive with other people. The poems, the lecture comment, and his prayer indicate a courageous willingness to accept unintegration, the unknown, the infinite. He was helpless with regard to his own dying and death—helpless in the sense that he could not alter these realities, and helpless in the sense of being unable to integrate them. Yet in this helplessness was an agency that accepted unintegration, and in his acceptance he continued to be creative and to experience being alive.

I suspect that Winnicott was anxious about his approaching death, but this anxiety was not only manageable; it was linked to his desire to say goodbye and to continue being creative as long as he was able. Per-

haps his ability to contain unintegration was the result of his deep sense of going-on-being, even in the face of the formlessness of nonbeing.

CONCLUSION

Winnicott's developmental theory takes seriously the reality of existential helplessness and absolute dependency in life, though it is framed in terms of the emergence of a child's ego, the true self, and the sense of going-on-being from the primary state of unintegration. I have argued that Winnicott's developmental theory contained four paradoxes that can be used to understand healthy and unhealthy stances toward existential helplessness and dependency. Religion, I have posited, serves as a case in point of the dynamic tension of these paradoxes, and that unhealthy religion can be seen as the collapse of these paradoxes toward one pole or another. Finally, I have pointed out that Winnicott's stance toward his own dying and death in his late sixties can be understood in terms of his theory of development and these four paradoxes.

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Saint Meinrad Seminary and School of Theology
200 Hill Drive
St. Meinrad, IN 47577

e-mail: rlamothe@saintmeinrad.edu

Volume LXXXIII, Number 4

THE INTERPLAY OF DEDUCTIVE AND INDUCTIVE REASONING IN PSYCHOANALYTIC THEORIZING

BY CHARLES HANLY

Deductive and inductive reasoning both played an essential part in Freud's construction of psychoanalysis. In this paper, the author explores the happy marriage of empiricism and rationalism in Freud's use of deductive reasoning in the construction of psychoanalytic theory. To do this, the author considers three major amendments Freud made to his theory: (i) infant and childhood sexuality, (ii) the structural theory, and (iii) the theory of signal anxiety. Ultimately, the author argues for, and presents Freud as a proponent of, the epistemological position that he calls critical realism.

Keywords: Deductive reasoning, inductive reasoning, analytic theory, critical realism, Freud, scientific observation, empiricism, subjectivity, epistemology, logic, psychic functioning, anxiety, phenomenology.

Deductive and inductive reasoning both played an essential part in Freud's construction of psychoanalysis. Inductive reasoning derives general truths from particular truths of observation and confirms (or falsifies) predictions and causal explanations. Deductive reasoning derives particular truths from general truths and the observational consequences of theoretical explanatory assumptions or causal laws. In ad-

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Charles Hanly is a Training Analyst of the Canadian Psychoanalytic Society and Professor Emeritus of Philosophy, University of Toronto.

A version of this paper was presented as the 2005 Freud Anniversary Lecture at the New York Psychoanalytic Institute.

dition, deductive reasoning allows us to draw out the implications, for psychoanalysis, of the findings in adjacent sciences, as Freud (1920) attempted in drawing upon cellular biology to shore up his postulate of a death instinct and as analysts now seek to do with recent findings in brain sciences.

These abstract definitions (of deductive and inductive reasoning) will be contextually illustrated, elaborated upon, and given further connotative and denotative definition as we proceed. In scientific thinking, these two forms of reasoning go hand in hand. As we proceed, we shall see why (and how) it is that inductive reasoning is fundamental.

Historically, the necessity of this alliance between inductive and deductive reasoning was not always fully understood. Bacon (1620), the father of inductive reasoning, did not appreciate the need for ideas and inferences drawn from them in the formation of scientific hypotheses that can be inductively tested. Descartes (1641) appreciated the role of ideas, but then exaggerated that role by assuming that all knowledge can be deductively derived from ideas that are clear and distinct, which are ideas Descartes took to be self-evidently true.

As a result, although Bacon made many observations, he did not advance scientific knowledge as did, for example, the ingenious William Harvey (1578–1657) in the field of anatomy. And despite having invented analytic geometry and having made original contributions to optics, Descartes was able to persuade himself that Harvey's demonstration of the circulation of the blood was grounded in a clear and distinct idea innate to the mind. Furthermore, despite his radical philosophical skepticism, Descartes failed to consider the possibility that physical space may not be rectilinear, as Euclid's synthetic geometry and his own analytic geometry assumed.

This dichotomy between empiricism and rationalism is bridged in scientific thinking and observing. Freud's (1915) working awareness of this integrated epistemological position is apparent in the following statement:

> We have often heard it maintained that sciences should be built up on clear and sharply defined basic concepts. In actual fact no science, not even the most exact, begins with such definitions.

> The true beginning of scientific activity consists rather in describing phenomena and then proceeding to group, classify and correlate them. Even at this stage of description it is not possible to avoid applying certain abstract ideas to the material in hand, ideas derived from somewhere or other but certainly not from the new observations alone. Such ideas—which will later become the basic concepts of the science—are still more indispensable as the material is further worked over . . . . We come to an understanding about their meaning by making repeated references to the material of observation from which they appear to have been derived, but upon which, in fact, they have been imposed. Thus, strictly speaking they are in the nature of conventions—although everything depends on their not being arbitrarily chosen but determined by their having significant relations to the empirical material. [p. 117]

Freud's statement agrees with a similar epistemological position set out by Einstein (1921) on the basis of his experience of having constructed relativity theory and seen it validated by predicted observations:

> The only justification for our concepts and system of concepts is that they serve to represent the complex of our experiences; beyond this they have no legitimacy. I am convinced that the philosophers have had a harmful effect upon the progress of scientific thinking in removing certain fundamental concepts from the domain of empiricism, where they are under our control, to the intangible heights of the *a priori*. [p. xvi]

I propose to explore this happy marriage of empiricism and rationalism in Freud's use of deductive reasoning in the construction of psychoanalytic theory. To do this, I will consider three major amendments Freud made to his theory: (i) infant and childhood sexuality, (ii) the structural theory, and (iii) the theory of signal anxiety. But before doing so, let me first clarify the epistemological position that I call *critical realism* (and which I share with Freud and Einstein) by means of a brief examination of the inferential reasoning used by Harvey in his discovery of the circulation of the blood.

Harvey's demonstration, contrary to Baconian inductive expectations, did not involve any direct observations of circulating blood in hu-

mans and/or other animals (Singer 1957). However, the truth of his deduction depended on a crucial observation of the amount of blood pumped from the heart of a sheep. The truth of the hypothesis about human anatomy (i.e., that the blood circulates) was deductively derived from observations of a naturally occurring simulation of the action of the human heart.

Originally, Harvey believed (with Galen, a Greek physician who lived during the second century AD) that blood was brought to the heart from the lungs and stomach by veins and distributed to the extremities by the pumping action of the heart. Existing anatomical ideas, based on Galen's work, held that the pumping action of the heart supplied energy and heat to the body which, having used up the supply, was smoothly resupplied by new blood from the stomach and lungs with each succeeding pulse. Harvey's ingenuity consisted, first, of daring to question the long-established authority of Galen by considering the contrary and alternative: a stable supply of blood pumped from and drawn back to the heart, enriched by nourishment and air from the stomach and lungs.

Second, Harvey correctly hypothesized, through deductive inference from Galen's explanation, that if the amount of blood pumped into the body by the heart was used up, the body would have to replace it by consuming and ingesting an amount of nourishment and air every twenty-four hours that would be equal to the mass of blood distributed by each pulse multiplied by the number of pulses in a day. This inference from Galen's theory was crucial because it linked the theory to observable reality in a way that made it empirically testable. It is upon inferences of this kind that the advancement of knowledge depends.

Since Harvey could not legally (or morally) measure the amount of blood pumped into the body by a human heart, he had to turn to a naturally occurring simulation, namely, a sheep with a heart and body of comparable size to the human heart and body. Having captured and weighed the blood from a single pulse of a sheep heart, Harvey made the calculation based on Galen's model, and found that it would be impossible for any sheep to ingest the gargantuan amounts of air, solids, and liquids required in a 24-hour period. Therefore, he concluded that the circulatory systems in mammals must be continuous.

This fundamental fact of human anatomy was derived deductively by Harvey without any direct observation of blood coursing through the human body, i.e., on the object that the circulatory theory accurately describes. But neither was it deductively derived from a Cartesian clear and distinct idea. It was derived from a combined use of deductive inference and observation that exploits the fact that there are only two alternatives: the anatomical system is either linear or circular (and not both).

The observation on the mass of blood in a pulse of a sheep's heart is the crucial fact, which enables an inductive inference to the circulatory systems of other mammals, on which the truth of the deductive derivation depends. From it, Harvey was able to also infer, without further observation, that arterial blood nourishes tissue from where the blood is taken up by veins and resupplied with the required nutriments as it is returned to the heart. Anatomical observation confirmed Harvey's inferences. One is reminded of Freud's (1895) deductive discovery of the neuronal synapses.

The bare bones of the deductive inference involved in Harvey's anatomical proof can be rendered in two syllogisms (a deductive form of argumentation). The first is an alternative syllogism:

1. Either the blood system of mammals is discontinuous or it is circulatory;
2. It cannot be discontinuous;
3. Therefore, it must be circulatory.

The second is a categorical syllogism:

1. The blood systems of mammals are circulatory (the conclusion above);
2. Human beings are mammals;
3. Therefore, the circulatory system of human beings is circulatory.

These deductive inferences can be shown to be formally valid. However, there is an inductive generalization upon which the whole depends: the generalization from sheep to the whole class of mammals. The de-

ductive argument is valid, but it is only sound, in the important sense of deriving a conclusion that is true, if the premises are true. Here the fundamental role of observation and inductive reasoning in science is clear.

Yet there is also a further factual consideration that bears upon the probability of the truth of this generalization. Could the environment sustain any mammal omnivorous enough to supply a discontinuous blood system? The answer would seem to be a resounding "not at all likely."

From these considerations, we can draw three epistemologically significant inferences: (1) deductive reasoning can provide only formal certainty (i.e., certainty subject to the condition that the premises it employs are true); therefore, (2) since knowledge depends upon observation, inductive reasoning is primary and sets limits to the certainty of knowledge; but, (3) Harvey's theory of the circulation of the blood in mammals qualifies for the highest level of probability because there is no reason to think that it could ever be vulnerable to negative instances.

As Einstein (1921) pointed out, systems of geometry are only formally certain until the axioms on which they are based are observationally tested, and then the best they can achieve are levels of empirical probability. By this measure, Freud's theory of unconscious psychic processes is much more probable than Euclid's axiom of parallels, even though Descartes believed the axiom to be self-evidently clear and distinct, because Euclid's rectilinear geometry of space does encounter fundamental negative instances in relativity physics.

If we now consider the impact of Harvey's deductive reasoning on his observations, we can see that he was decisively influenced in his search for telling observations by the idea that he should consider the amount of nourishment needed to supply a discontinuous blood system. The idea told him what he should look at. But the epistemological influence of the idea does not extend so far as to influence the observation he made, i.e., the mass of the blood or his method of measurement. His guiding idea, which determined the measurement he needed to make, did not alter the weight of the blood pumped into the body by one pulse. This value was not epistemologically compromised by Harvey's guiding idea. Harvey's anatomical finding refutes all those who would claim that science in general is, in principle, unable to ground its knowledge in

reliably objective observations that are not compromised by the observer or by his methods of observation.

However, what if clinical observation in psychoanalysis, unlike observation in other sciences, is unavoidably subjectively compromised—"irreducibly subjective," as it has been characterized (Renik 1993)—and thus compromised in principle or a priori? What if psychoanalysis is fated never to be able to meet Einstein's standard of scientific knowledge? Certainly, clinical psychoanalysis is dependent upon the observation of the qualities of the psychic lives of persons rather than upon the quantification of any of their physical properties. Morality prohibits clinical experimentation on patients. No other animals are equipped, so far as we know, with psyches that could be used to simulate the human psyche—that is, there is no equivalent to Harvey's sheep's heart. It would be reasonable to assume that psychic reality is more difficult to observe than physical reality.

Moreover, contemporary psychoanalysts of the subjectivist school will assert, contrary to critical realism, that objective observation is an authoritarian myth and that thinking is irremediably a priori, since the mind has no alternative but to impose, in some Kantian-like fashion, the stamp of itself in the construction of everything it perceives or contemplates. Critical realism, on the other hand, is the epistemological idea that there is a real world existing independently of our senses that we can know, to some extent, by the use of appropriate methods of observation in science and through unaided observation that allows us to acquire commonsense knowledge of other persons and other things.

Freud (1927) advanced a group of arguments against the subjectivist position in epistemology, of which I will mention three:

1. The human mind has "developed precisely in the attempt to explore the external world, and it must therefore have realized in its structure some degree of expediency" (p. 55) in testing reality: an evolutionary argument.
2. The human psyche is part of nature and as knowable as any natural object: an ontological argument.
3. The human mind is not only determined by its own organization, but also by the objects that affect it: a psychological argument.

To these I would add a historical/developmental argument. The animistic cultures of ancient times owed their psychological origins to ancient men and women projecting their own psychic nature onto objects (Hanly 1988a). As these projections gradually diminished (a process that Epicurus tried to hasten with his philosophy of material naturalism), the material nature of physical objects became more apparent to the senses and more conceivable by the intellect. The human mind was becoming more affected by objects than by itself, and in so doing it was undergoing what Freud (1927) called an "education to reality" (p. 49), which generated a reduction in cognitive subjectivity and an increase in the capacity for realism and the satisfaction of curiosity for its own sake (which cleared the way for science and motivated inquiry).

This profound transformation in human experience of nature is the dominant paradigm shift of civilized life, and it was not limited to the experience of the physical world. It equally transformed self-experience and the experience of others (Hanly 1988b). The same transition takes place in the development from early childhood to latency in modern human beings. Ego regression involves the loss of objectivity when projections, denials, and splitting dominate perception and thought. Hence, although objectivity is an achievement rather than a given, cognitive subjectivity can be reduced and, when it is, objectivity becomes proportionately more attainable. An early psychoanalytic account of the psychology of this process of education to reality during infancy and childhood was insightfully sketched out by Ferenczi (1913).

Concerns about the reliability of psychoanalytic clinical observation will continue, as they should. There is no end to the need to critically observe and correct our clinical observing, just as there is no end to the need to test our clinical responsiveness, countertransferences, and our interpretations against changes in the patient's transferences, associations, and functioning inside and outside the analytic situation. Analysts who have espoused a subjectivist epistemology have contributed usefully to the inventory of the ways in which analysts fail to allow the patient to *be* and to be understood.

The problem is not with the criticism—namely, that some clinical observations of analysts are subjective—but with the assertion that all clinical observations are necessarily subjective. Without ideas there can

be no observation, and without observation we cannot know what our ideas should be or whether or not they are reliable. I endorse the critical realist assumption that, while many difficulties stand in the way of our understanding human psychic reality, with psychoanalytic insight into these difficulties they can be overcome sufficiently to bring therapeutic benefits to our patients and to build a body of scientific knowledge.

I now turn to an exploration of the interplay of deductive and inductive reasoning in Freud's construction of psychoanalysis with a consideration of (i) infant and childhood sexuality, (ii) the structural theory, and (iii) the theory of signal anxiety.

CHILDHOOD SEXUALITY

Freud's first attempt at an explanation of neurosis was his seduction theory, which focused on sexual seduction in childhood. The memories of these experiences, when revived and their meaning apprehended with the onset of sexuality (at this time, Freud assumed that sexuality originates with the physical and mental changes experienced at puberty), cause psychological symptoms when, on account of moral or aesthetic anxiety, they are subjected to repression in adolescence.

The theory's clinical and therapeutic corollary was the cathartic theory. Freud introduced the required supplementary hypothesis of *deferred action* to account for the delay of the symptomatic appearance of the trauma from childhood to puberty. These and other hypotheses making up the total theory were coherent, i.e., logically consistent with each other.

Freud's proud enthusiasm for his theory, for which he was prepared to risk his friendship with Breuer and his reputation, was short-lived (Freud 1897). The theory predicted symptom remission and functional improvements when the childhood scenes of seduction were recalled and their affects were abreacted, but these remissions were not regularly occurring and were temporary when they did (Freud 1897, 1925, 1933). Here we come upon an example of Freud's deductive thinking (the Cartesian element) at work in his drawing out, in the form of a hypothetical syllogism, the observable clinical outcomes predicted by his theory.

We also come upon a crucial aspect of Freud's inductive thinking (the Baconian element): his search for negative instances, that is, clin-

ical observations that would falsify his theories. Freud's thinking willingly paid homage to the codependency of inductive and deductive thinking in scientific work and tolerated the misery of a negative outcome; "I am tormented by grave doubts about my theory of the neurosis" (Freud 1897, p. 259). Freud submitted to the impersonality and the sublime indifference of logic and fact to our wishes.

For the purposes of this exposition, I will disregard the other cogent reasons that Freud (1897) had for doubting his *neurotica* (except for the second argument, which is built into the discussion below), in order to proceed at once to the reasoning that opened the way forward to Freud. Freud's starting point was his observation of affect-laden scenes of seduction occurring in his patients' free associations. One of the tasks of scientific thought in the Renaissance was to *save the appearances*. For example, one of the great appearances that theory in astronomy had to save, in order to rid itself of the Ptolemaic epicycles, was the apparent diurnal rotation of the heavens around the earth, plain for every observer to see. Both objectives were accomplished by Copernicus's theologically unwelcome hypothesis of the diurnal rotation of the earth on its axis, which revealed the apparent motions of the sun and other heavenly bodies to be an unavoidable visual illusion caused by the diurnal rotation of human observers.

This great discovery in astronomy reveals the shortcomings of naive or simplistic realism linked to inductive reasoning. Ordinary perceptual experience teaches us much about nature. But it also keeps some of the most fundamental facts of nature secret. It was reason (rather than experience) that led Copernicus to the hypothesis that would reveal the astronomical secret of the earth's rotation. The task posed for Freud was to save the scenes of sexual seduction disclosed by his clinical observations, scenes that his seduction theory took to be memories of real historical events.

There were three possibilities: the seductions were either inflicted, imagined, or suggested. The logical alternation in this enumeration of possibilities is not exclusive as it was with Harvey's alternatives (i.e., in Freud's case, all three alternatives could be true). Freud's disjunctive alternatives are mutually compatible. A patient could have imagined being seduced, as well as having suffered seduction at the hands of another,

and the patient's awareness of these events could be the result of a resistive, intellectual compliance with the importuning of an overzealous, dogmatic, and naive therapist, rather than an authentic recovery of remembered events or wishful fantasies.

Freud realized that, although childhood seduction when combined with a "failure of repression" could be a sufficient cause of neurosis in adults, it is not a necessary cause. It is implausible to suppose that seductions could account for the number of neuroses that occur because it would require a yet greater number of perverse parents (especially fathers, including his own). This argument is based on impressions and estimations rather than observations.

However, Freud (1897) did have a reason for thinking that the incidents of seduction would have to be greater than the incidents of neurosis. Conditions in addition to a history of childhood seduction—specifically, "a failure of repression"—would also have to have occurred. What the argument needed were occurrences of neuroses despite the absence of seduction.

During this period of searching for a better theory, Freud's self-analysis provided him with such a case. At first, he traced his hysteria and travel phobia to a memory of having been seduced by his father. But in the next months, Freud recaptured more early childhood memories, including a memory of his nurse. These memories, corroborated in some important details by his mother, provided him with two important pieces of evidential data: first, the part his own childhood sexuality played in his predisposition to hysteria, and second, the realization that a memory of seduction by his father had been a disguising fantasy.

Here we come upon the crucial inferential step that revolutionized Freud's thinking. The basic ideas of infantile sexuality and the substitution of a fantasy for reality came from Freud's self-analysis and his clinical experience. He was able to stumble on them because of the defeat of his efforts to clinically confirm the seduction theory. What could "save the appearance" of memories of sexual seduction that arose in the free associations of patients in analysis? They could be explained if fantasies, strongly invested with the patient's sexual wishes, had been subjected to repression—only to reappear later as memories of childhood sexual seductions associated with neurotic symptoms.

This hypothesis had a number of crucial implications. First, the underlying psychic processes involved in symptom formation do not differentiate fantasy from reality. This implication agreed with Freud's clinical observations and, in particular, with his growing realization that dreams are disguised wish fulfillments of hallucinatory intensity. The hypothesis became a cornerstone of the topographical model, i.e., it became the primary differentiation between unconscious and conscious thought activity by defining the cognitive and volitional (motivational) liability of the pleasure principle. This implication would help account for the appearance in consciousness of fantasies as memories of actual happenings.

Second, psychic development can be as influenced by such fantasies as by real experiences. If so, this causal efficacy is a constitutional factor that partially defines psychic reality. Third, sexuality has its onset with birth and not with puberty, when it makes the final transition to its adult genital organization. This last implication, combined with the second, has the further implication that human sexuality enters into the fabric of human experience and development prior to genital sexuality and serves functions other than reproduction. This inherited organizing, constituting, and motivating function of sexuality in psychic development led Freud to introduce the term *libido* in place of *sexuality* to signal these far-reaching conceptual differences.

These ideas owe their origin to experience, even though the processes and experiences to which they refer are partly caused by genetic inheritance. They are Baconian empirical concepts consistent with Locke's (1690) idea of the mind as a tabula rasa. They are very far from Cartesian innate ideas, even though they owe their origin to innately caused self-experience (Hanly 1988b). However, their place in psychoanalytic theory, their interconnections, and their implications were worked out deductively. At this stage, Freud was not primarily seeking clinical confirmation of causal hypotheses or descriptive generalizations, although he clearly had this possibility in mind; he was rather considering the question, "What could account for the prevalence of scenes of sexual seduction appearing as memories of real experiences in the associations of neurotic patients?"

The ideas elaborated above form a group of hypothetical ideas that, if true, would account for the occurrence of these scenes and their pathogenic consequences, despite the absence of a history of sexual seduction. They form a logically connected group of hypothetical ideas from which explanations can be constructed and predictive inferences drawn, which can then be inductively tested by clinical observation. By treating libido as an instinct and by postulating further that fixation and regression are the two major vicissitudes of instinct, Freud was able to account for the predisposition to neuroses, the psychic processes at work in dreams, parapraxes, and symptoms, as well as significant elements of character formation. Freud's reasoning generated explanations for previously incomprehensible aspects of human psychic activity.

THE STRUCTURAL THEORY

The topographical model contained a serious flaw. Moral and aesthetic imperatives and ideals that oppose certain libidinal demands were located topographically along with perception, thought, and behavior within consciousness. From this locus, these imperatives could successfully oppose libidinal demands for satisfaction. Since ego functions are subject to the overarching reality principle, it follows that the imperatives and ideals of moral and aesthetic conscience have been subjected to reality testing, which has established their benefit to the individual.

Thus, although conscience contributes to psychopathology by opposing the satisfaction of fixated or regressed libidinal wants, conscience is not itself subject to psychopathology. Included in the task of psychoanalytic treatment is the maturation of libidinal wants so that they will no longer be in conflict with conscience. What is repressed is unconscious, but what does the repressing is conscious—or at most, preconscious.

The reasoning that contradicted this implication of the topographical model can be summarized as follows:

1. If the unconscious is the repressed, then what does the repressing is conscious;
2. But what does the repressing is unconscious;
3. Therefore, the unconscious cannot be equated with the repressed.

This reasoning has the form of a modus ponens, hypothetical syllogism, i.e., an argument in which the consequence of a hypothetical proposition (first premise) is false (second premise) from which it validly follows that the antecedent of the first premise is false. Freud (1923) stated this conclusion of his reasoning as follows: "We recognize that the Ucs. does not coincide with the repressed; it is true that all that is repressed is Ucs., but not all that is Ucs. is repressed" (p. 18). Here Freud is correctly relying on the fact that the subject (but not the predicate) of universal affirmative categorical propositions is distributed. This means that, unlike universal negative categorical propositions, in which both subject and predicate are distributed, they cannot be converted.

Again, we notice the interdependence of inductive and deductive reasoning in scientific thinking. The first premise is a deductive inference from the topographical model, the truth of which is being evaluated. The truth of the crucial second premise (i.e., that which does the repressing is unconscious) is inductively established by clinical experience. The evidence for the truth of the second premise, cited by Freud (1923), is that the motives of repression are "also unconscious and . . . require special work before . . . [they] can be made conscious" (p. 17).

Further specific clinical evidence for its truth is the *negative therapeutic reaction* (Freud 1923). The conclusion is the cornerstone of the structural theory. Once laid down, this cornerstone opened the way for Freud's (1923) account of the crucial contribution of the resolution of the Oedipus complex to the formation of conscience and its vulnerability to psychopathology when this resolution is imperfectly accomplished.

THE THEORY OF ANXIETY: FROM CONVERSION TO SIGNAL

Freud's first theory of anxiety was the conversion theory. But despite phenomena that appear to corroborate it, Freud (1926) found it necessary to fundamentally revise it. The conversion theory of anxiety had a fatal flaw. In the conversion theory, anxiety is a byproduct of repression. When a libidinal demand undergoes repression, the pleasure that would otherwise have attended its fulfillment is converted into unpleasure in the form of anxiety.

This account of the genesis of anxiety appears to be confirmed by, for example, the patient who, while driving to pick up his mother at the airport shortly after the death of his father, is overtaken by the anxiety that he is having a heart attack similar to the one to which his father has recently succumbed. An old incestuous, possessive wish, revived by his father's death, has been further stimulated by his mother's arrival for a visit after the funeral, and has undergone repression. The conscious product of this repression is the experience of being overwhelmed with anxiety about suffering his father's fate, to such an extent that he has to pull off the road and be taken to an emergency ward by a concerned motorist. At the hospital he is assured, but not convinced, that his heart is perfectly healthy.

It is not difficult to notice the same sequence—forbidden libidinal impulse, repression, anxiety—in cases other than conversion hysteria as well, such as in obsessional rituals (Freud 1916–1917) and phobias (Freud 1909, 1918). Baconian (and even Humean) empiricism would justify Freud's inductive inference that anxiety is caused by the conversion of libido into anxiety by repression of the libido.

Indeed, Freud (1916–1917) generalized from libidinal impulses to any affect or impulse, including aggression: "Anxiety is therefore the universally current coinage for which *any* affective impulse is or can be exchanged if the ideational content attached to it is subjected to repression" (pp. 403-404, italics in original). But more particularly, neurotic anxiety is the discharge of libido, "which is subjected to repression" (p. 410). Hence, neurotic anxiety is a vicissitude of libido and has its origin in the instinctual unconscious, whereas realistic anxiety is a similar vicissitude of ego-libido or narcissism.

However, despite the ease and frequency with which this sequence is observed, the conversion theory cannot be true, that is, it cannot offer a consistent explanation of the genesis of anxiety. Repression is a psychic process. All psychic processes are motivated. Hence, repression too is motivated. Repression and other defensive processes do not occur randomly or arbitrarily. What else but anxiety, then, we must ask, could motivate defensive processes—not in the sense of guiding or directing them, but in the sense of activating and setting them in motion? There has to be a source of anxiety that precedes any anxiety resulting from

the conversion of libido by repression. Anxiety must have a genesis that is independent of and precedes the repression of libido.

Freud's theory of *signal anxiety* resolves the explanatory dilemma of his conversion theory. His new theory of anxiety allowed him to abandon the dubious thesis that anxiety, including even realistic anxiety, is inexpedient and that only realistic action taken to avoid danger is expedient. Instead, Freud was able to assume that the capacity to be mobilized by anxiety could well be the result of the evolutionary expediency of this capacity. It allowed him to postulate that it is from the ego that anxiety proceeds as a result of the stimulation of a memory of painful helplessness. He could hypothesize that in any individual life history, the original experience of helplessness could be birth. The theory allowed Freud to interconnect anxiety with libido (and aggression) by tracing the progressive enrichment and modification of the anxiety template consequent upon its links to the stages of psychosexual and ego development: fear of loss of the object, fear of the loss of love of the object (shame), fear of parental revenge, fear of self-imposed retribution (guilt).

Neither are two principal advantages of the conversion theory lost. A libidinal or aggressive demand is still the precursor of the anxiety, and the strength of the anxiety is still proportional to the strength of the unconscious demand for satisfaction. The change in the sequence of events is the exchange of places whereby anxiety intervenes and a defensive process is mobilized. Consequently, it still follows that sexually inhibited persons are not sexually inhibited merely because they are anxious persons in the sexual sphere (as well as others). They are sexually inhibited because unconscious sexual wishes have made them anxious.

Here there is no claim that Freud actually followed this course of deductive reasoning. In fact, he states just the opposite: "It is not so much a question of taking back our earlier findings as of bringing them into line with more recent discoveries" (1926, p. 141). Freud goes on to reaffirm that "anxiety arises directly out of libido" (p. 141) in the "actual" neuroses, as a discharge of the "surplus of unutilized libido" (p. 141). It was not until later that Freud (1933) published his abandonment of this last vestige of his hypothesis of a direct conversion of libido into anxiety altogether.

My assumption is that the discoveries to which Freud is referring are observational rather than conceptual. My point is that the hypotheses of Freud's theory are sufficiently rich, reality bound, and inferentially interrelated that theoretical reasoning, even without observation, can identify explanatory problems and indicate the direction in which a solution may be found, even in the face of apparent observational confirmation of the theory that can be shown to be theoretically unviable. This truth about psychoanalytic theory does not depend upon its having been recognized by its creator. However, everything happens as though Freud knew that his conversion theory of anxiety was, at best, so incomplete that its generalization produced a contradiction; it presupposes anxiety of a different nature from another source to motivate the repression required by the conversion theory.

Thus, even though he did not finally surrender his attachment to the phenomenological and observational grounds for conversion anxiety until more than a decade later (Freud 1933), this assumption would account for the fact that all the elements of the signal theory of anxiety are already present in Freud's (1916–1917) most complete statement of the conversion theory. Some explicit Cartesian deductive logical analysis of the theoretical implications of the conversion theory could have hastened Freud's reformulation.

This speculative reconstruction calls our attention to certain logical and rational functions of the economic unconscious. We habitually evaluate our own reasoning and the reasoning of others without being aware of doing so, even without rendering our thoughts into their logical form as I have done above. This evaluation is carried out by a savoir-faire about valid reasoning exercised by a reflexive critical function that is not already outfitted with the formal means of evaluating validity. Unless one has studied formal logic, one would make the judgment that the syllogisms I have constructed are valid on the basis of this preconscious critical function, which appears to be the byproduct of the acquisition of language and those experiences of practical successes and failures in reasoning that tutor us in the structure of reality. Boolean class logic, the algebraic expression of the structures of propositions, Venn diagrams, systematic symbolic logic, and Wittgenstein's truth tables are not Cartesian innate ideas that could provide a foundation and guide for the infal-

lible exercise of this critical function. This imperfect, usually inarticulate but reasonably functional sense of logical validity and invalidity is an essential component of reality testing.

It is remarkable that this logical, evaluative function is as reliable as it is, but it is by no means infallible. We are quite able to overlook inconsistencies, contradictions, and explanatory inadequacies in our thinking—not only on account of unconscious conflicts or narcissism, but also on account of apparent but superficial or erroneous observational confirmation. Our ordinary experience of the apparent motion of celestial bodies offers no observational clue that the earth is rotating daily on its axis; the perceptual illusion is complete. Only reason employing abstract thought can find the way to correct our understanding, and the correction of our understanding alters nothing in our perceptual experience; it alters only our understanding of our perceptions by teaching us to compensate for the motion of the platform from which we perceive. Further, we can use our perceptions to successfully satisfy purposes even while naively trusting false beliefs about what we see. We can go on believing that the sun rotates around the earth while successfully using its locations during the day to orient ourselves in space and time. Here we come upon the limits of pragmatism rather than the relativity of truth.

Nevertheless, without subscribing to Kant's (1781) a priori (a way of gaining knowledge without appealing to any particular experience), we can agree with him that concepts without perception are empty, while perceptions without concepts are blind. This formulation agrees with the epistemological insight shared by Freud (1915) and Einstein (1921). Although abstract concepts need not be directly derived from observations, their usefulness for building knowledge depends upon their being confirmed by observations. Consequently, the basic epistemological issue for psychoanalysis is whether or not the analytic situation and the individual psychic life we seek to know can yield reliable enough observations to confirm (or disconfirm) the ideas upon which we have to rely to make them.

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106 Elm Avenue
Toronto, Ontario
Canada M4W 1P2

e-mail: charlesmhanly@gmail.com

Volume LXXXIII, Number 4

OBJECTIVITY AND SUBJECTIVITY IN THE EVOLUTION OF PSYCHOANALYTIC THEORIES

BY ANDREW B. DRUCK

Keywords: Objectivity, subjectivity, analytic theory, Charles Hanly, critical realism, hypothesis, Freud, history of analysis, epistemology, natural science, observation, deduction, clinical facts.

Dr. Charles Hanly's paper, "The Interplay of Deductive and Inductive Reasoning in Psychoanalytic Theorizing," provides us with a welcome opportunity to discuss the process of constructing and refining psychoanalytic theories. Hanly presents a relatively straightforward account of change in psychoanalytic theory, concentrating on the evolution of Freud's ideas. He argues that psychoanalytic theory, like theory in the natural sciences, has evolved through the interplay of deduction and induction, in which induction is based on assessment of psychoanalytic facts, i.e., clinical observations. The epistemological context within which this process occurs is that of *critical realism,* rather than *irreducible subjectivity,* which interferes with objective assessment of clinical observations.

However, other important assumptions and assertions are embedded in Hanly's argument, and they are best discussed as they emerge in the course of that argument. Therefore, I will structure my discussion through my reading of Hanly's paper, as I try to follow his thinking and highlight assumptions that deserve further exploration. I will then briefly discuss two issues raised by Hanly: subjectivity in psychoanalytic theorizing and the relation of a psychoanalyst to his or her theory.

Andrew B. Druck is a fellow (Training and Supervising Analyst), past president, former dean of training, and faculty member at the Institute for Psychoanalytic Training and Research (IPTAR) in New York. He is an Adjunct Clinical Assistant Professor of Psychology, faculty member, and Supervising Analyst at the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis.

Hanly begins by stating that inductive and deductive reasoning go "hand in hand" (p. 898) in scientific thinking, and that the interplay between these forms of reasoning was not always understood. Freud, however, did understand this "alliance" (p. 898), as Hanly illustrates with two quotes from Freud. Hanly uses these quotes to support a major thesis: that one can view Freud's process of theory revision as an illustration of how, in the process of scientific theory construction and evolution, inductive and deductive reasoning go hand in hand. In this process, he writes that "inductive reasoning is fundamental" (p. 898).

Hanly proposes to explore this idea by considering how Freud amended his theory in three instances in which clinical observations did not accord with deductive hypotheses. However, before moving to this issue, Hanly detours into discussing another issue, an epistemological position of "critical realism" that he shares with Freud and that he illustrates with a discussion of William Harvey's discovery of blood circulation.

Hanly provides us with a clear discussion of what he sees as Harvey's thought process. Discovery occurred because Harvey was able to move from deduction—i.e., hypothesis creation—to observation, which could confirm or disprove the hypothesis. Hanly goes on to state:

> If we now consider the impact of Harvey's deductive reasoning on his observations, we can see that he was decisively influenced in his search for telling observations by the idea that he should consider the amount of nourishment needed to supply a discontinuous blood system. The idea told him what he should look at. But the epistemological influence of the idea does not extend so far as to influence the observation he made, i.e., the mass of the blood or his method of measurement. His guiding idea, which determined the measurement he needed to make, did not alter the weight of the blood pumped into the body by one pulse. This value was not epistemologically compromised by Harvey's guiding idea. Harvey's anatomical finding refutes all those who would claim that science in general is, in principle, unable to ground its knowledge in reliably objective observations that are not compromised by the observer or by his methods of observation. [pp. 902-903]

Let us pause for a moment and see where we are. Hanly is arguing that there is an interplay between hypothesis and observation—that hypothesis tells us where to look, but ultimately, it is what we find when we observe that is fed back into our hypotheses, into our theoretical assumptions, so that these are modified in accord with the data. This is a scientifically productive feedback loop.

By using Harvey's work as an illustration of this point, Hanly is connecting theory construction in natural science, where data is clear and more "objective" (for example, a mass of blood), and theory construction in psychoanalysis, where data is much less clear, less "objective," and much more susceptible to different constructions. Yet Hanly seems to equate the two in his presentation of why critical realism should be the epistemological context within which we construct our psychoanalytic theories.

So we have three embedded assumptions here: that psychoanalytic theory is similar enough to that of natural science for both to evolve according to a common pathway; that psychoanalytic data is similar to the data of, for example, biology; and that an attitude of critical realism is necessary in order for our observations to remain objective, scientific, and not compromised by our subjectivity.

Hanly addresses these assumptions in two important paragraphs. He writes:

> However, what if clinical observation in psychoanalysis, unlike observation in other sciences, is unavoidably subjectively compromised—"irreducibly subjective," as it has been characterized (Renik 1993)—and thus compromised in principle or a priori? What if psychoanalysis is fated never to be able to meet Einstein's standard of scientific knowledge? Certainly, clinical psychoanalysis is dependent upon the observation of the qualities of the psychic lives of persons rather than upon the quantification of any of their physical properties. Morality prohibits clinical experimentation on patients. No other animals are equipped, so far as we know, with psyches that could be used to simulate the human psyche—that is, there is no equivalent to Harvey's sheep's heart. It would be reasonable to assume that psychic reality is more difficult to observe than physical reality.

> Moreover, contemporary psychoanalysts of the subjectivist school will assert, contrary to critical realism, that objective observation is an authoritarian myth and that thinking is irremediably a priori, since the mind has no alternative but to impose, in some Kantian-like fashion, the stamp of itself in the construction of everything it perceives or contemplates. Critical realism, on the other hand, is the epistemological idea that there is a real world existing independently of our senses that we can know, to some extent, by the use of appropriate methods of observation in science and through unaided observation that allows us to acquire commonsense knowledge of other persons and other things. [p. 903]

Again, let us pause to catch up. Hanly agrees that psychoanalytic observation differs from scientific experimentation in major ways, including that psychoanalytic data is different from scientific data and is more difficult to measure. Hanly then makes a sharp distinction between a "subjectivist school" and "critical realism." What is the distinction? Either that there is no outside world that we can truly observe and know, since our observations are irretrievably compromised by our subjectivity, or that there *is* an outside world that we *can* know objectively. Hanly confounds two issues: the degree to which our subjectivity influences our capacity to make reasonably accurate observations of a world that exists independently of us, and the question of whether there is, in fact, a "real" world that we can possibly know.

Hanly then brings in arguments—from Freud as well as his own—to buttress what seems to me to be an unnecessary and false dichotomy. In his contrast between positions, Hanly implicitly equates acknowledgment of a subjective element in observation to the notion that there is no real world existing independently of our subjectivity.

He then returns to the question of whether psychoanalytic data and psychoanalytic theory construction can fit the scientific model and "critical realism." Note that he conflates the question of whether scientific data is sufficiently similar to psychoanalytic data with the question of how "objective" one can be in observing and evaluating such data. Hanly believes that, of course, we need to continually test our observa-

tions against our countertransferences (thus acknowledging the pull of inevitable subjectivity). He writes:

> The problem is not with the criticism—namely, that some clinical observations of analysts are subjective—but with the assertion that all clinical observations are necessarily subjective. Without ideas there can be no observation, and without observation we cannot know what our ideas should be or whether or not they are reliable. I endorse the critical realist assumption that, while many difficulties stand in the way of our understanding human psychic reality, with psychoanalytic insight into these difficulties they can be *overcome sufficiently* to bring therapeutic benefits to our patients and to build a body of scientific knowledge. [pp. 904-905, italics added]

Thus, there is inevitable subjectivity, but this can be "overcome sufficiently" to allow the analyst to make relatively objective observations that he can use to modify his theory.

Hanly has now presented three interrelated but separate theses. The first has to do with psychoanalytic theory construction and the interplay of deduction and observation. This is the manifest topic of his paper. Embedded in his primary argument is the hypothesis that psychoanalytic data and observation of this data are close enough to scientific data and observation of such data that distinctions he himself acknowledges may be minimized.

Hanly's third thesis has to do with his sharp distinction between a subjective approach and critical realism. This seems to be central to his paper. Hanly presents a cursory discussion of the latter two hypotheses and prepares to illustrate his first argument using Freud's shifts in his theory.

Before we proceed to Hanly's discussion of Freud's theoretical evolution, let us take a moment to discuss this epistemological issue. It is striking that Hanly cites only one author (Renik) in his dismissal of the analyst's and the analytic theorist's subjectivity. As Hanly knows quite well, the issue of what is a clinical "fact" and how an analyst's subjectivity enters into determination of such facts is a complex one. As he is also aware, the International Psychoanalytical Association has organized sym-

posia on three continents to discuss these questions, and papers on this topic by a number of internationally renowned analysts were published to commemorate the 75th anniversary of the *International Journal of Psychoanalysis* (Tuckett 1994), with subsequent discussions by Cooper (1996) and Schwaber (1996).

One common conclusion about the relation between our theories and our observations (our clinical facts) is stated by Gardner (1994): "The facts we *construct* are inseparable from the theoretical and other subjectivities that go into our assumptions, observations, and conclusions" (p. 934, italics added).

Cooper (1996) observes that our theories themselves express our subjectivity (instead of—as Hanly is asserting, I think—that our theories are hypotheses based on our observations under the rubric of critical realism and modified based on those observations). Essentially, it seems almost impossible to separate a psychic "fact" from its observer's subjectivity. Cooper writes:

> Our unconscious predilections for a particular kind of fact or theory always determine, in part, what we observe or, if you will, what we wish to observe. Indeed, I will suggest that our very choice of theory expresses all kinds of aspects of our subjectivity in the analytic process. [1996, p. 256]

Finally, Cooper states that psychoanalytic facts, almost by definition, are not only subjective—not only based on deductive hypotheses that themselves express the analyst's theoretical predilections and subjectivity—but are also transient. Cooper cites Gardner in writing that "a fact is a fiction with a transient credibility and a passing utility" (p. 260).

Facts are fictions because they are always provisional attempts to create meaning, and because our understanding of the meanings of these facts, of their current and past use within an intrapsychic dynamic framework, changes—both within an analytic hour and over time. I believe that the analyst may be able to think of certain interpretations (which are forms of hypothesis testing), or may be able to suddenly see data that he has missed all along, *only* when there is a subjective shift, either internally or in the analytic field.

While psychoanalytic therapy and theory certainly involve content, both are primarily concerned with process, with how "facts" and data continually change meaning and context until an internal structural gestalt shifts. As Loewald (1973) writes, "For the child the reality of parents and other objects changes as he matures, he does not simply relate in a different way to fixed, given objects" (p. 13). Loewald compares this process to that of

> . . . intrapsychic reconstructions, non-objective, if I may use this term here in a sense similar to what we mean when speaking of non-objective art. There, too, a destruction of the object and of the ordinary relations with the object takes place, and a reconstruction, following new principles of structuring. We may say that non-objective art, by communicating such novel structuralization, opens up new dimensions of reality organization. [p. 12]

Loewald makes a similar point in a famous statement in his paper on therapeutic action in psychoanalysis, when he distinguishes between "new discovery of objects" and "discovery of new objects" (1960, p. 18). In the former situation, there is change in our experience of reality. Facts become understood differently with new perspectives. We are left with a continuing paradox: external reality itself has not changed. Things *did* happen. However, in our memory and experience, in the "reality" of our internal world, external reality has now been reconstructed in subtle ways, ranging from different feelings about what happened to different understandings of what happened and of the characters in that reality.

Every "fact" is both a fact and a fiction. It is a fact in that it corresponds to something that exists, something that is "true." Something really happened; a patient really does feel something; an internal mental process really exists. Yet that same fact is also a fiction in that it is remembered or enacted at a given time within a given intersubjective field or internal state for a given dynamic motive. In that way, a psychoanalytic fact is provisional, since the process, the context, the internal moment are all fluid and in dynamic equilibrium.

So when we observe, are we observing the "truth" of an event—that, for example, a patient's parents divorced when he was young—or the "truth" of that fact's use at a given moment? In the latter case, our obser-

vations move to the "truth" of a given dynamic and therapeutic process and to the psychic function of a particular truth for the patient at a given time.

For all these reasons, Cooper (1996) concludes that psychoanalysis is different from natural science. Psychoanalysis has a "special status," and the analyst has "a foot in both the realms of natural science and art" (p. 261). Cooper writes that this is the consensus of the majority of authors who published in the special anniversary issue of the *International Journal of Psychoanalysis* mentioned earlier.

The view of psychoanalysis as distinct from natural science is applicable not only to clinical work; it also leads to our development of different perspectives on our theoretical assumptions. For example, we now understand defense as an intrapsychic capacity that develops and evolves; signal anxiety, too, is seen as a developmental achievement; and resistance prevents one kind of communication even as it expresses something in a different modality. These multiple perspectives affect how and what we observe and how we can—correctly, if I may assume objectivity is possible for the purpose of this point—understand the same clinical "fact" differently at different moments in treatment.

Analysts as disparate as Brenner (1994) (who sees everything as the product of unconscious compromise formation), Jacobs (1999), Gabbard (1997), and Katz (1998), among many others, have focused on the constant interplay between an analyst's objectivity and subjectivity, with the analyst's subjectivity (and the nonverbal interplay between patient and analyst) becoming yet another source of data (not a "fact") about a patient's inner world. The issue is not to "overcome" countertransference, as if that were an alien force. Rather, it is to note and productively utilize the constant interweaving of "rational" thought and "irrational" thought—also viewed as the interplay of clinical observation and countertransference, or the analyst's perceptions within the context of an intersubjective field that has been created by patient and analyst, or the interplay of clinical intuition and data that may or may not validate such intuition (Arlow 1979).

I think that an analyst who is consciously and unconsciously trying to "overcome" his countertransference (which, by traditional definition, is inevitably unconscious and cannot be readily known) is *less* capable of

"objectivity" than one who tolerates and holds his subjective reactions and uses them as data. The latter analyst, less defensive, is more capable of objectivity.

It is within this context that we decide what constitutes clinical data and what we infer from it. We collect our data, assess it as best we can (Arlow 1979), and intervene. In such a context, irreducible subjectivity does not have to mean that there is no external reality independent of the analyst; of course, there is an external patient with his own internal psyche. It does mean that there is constant interplay of objectivity and subjectivity in our observations and our inferences from these observations.

Every aspect of the scientific process that Hanly describes is both objective and subjective—what hypotheses we make, what we deduce from them, what we choose to observe, and what we deduce from these observations. It is no accident that our understanding of issues of self, of preoedipal factors, of psychic development, of internal object relations and their role in internal life, and many other such issues have developed in historical and sociological contexts away from Freud's world. *What* we could see changed as what we were *sociologically allowed* to see shifted, as our social contexts shifted, and as our psychoanalytic group dynamics shifted (Eisold 1994; Jacobs 1999). We became more aware of issues that Freud underemphasized or simply missed—we became more *objective*, clinically and theoretically, as our *subjectivities* changed. This has less to do with a process of deduction and induction and more to do with the context within such a "scientific" process occurs.

All this raises some questions for me, as I will explain. Hanly is a renowned scholar with expertise in precisely this area of psychoanalytic epistemology. Let me try to, as Hanly puts it, "save appearances" (by which is meant, I believe, accounting for our observations even as we question earlier understandings of those observations). I am certain that Hanly is familiar with everything I am stating here. Why then does he cite only Renik's (1993) term *irreducible subjectivity* (a bit out of context, by the way; Renik's is a paper about psychoanalytic technique, and I do not believe he ever denies an objective external reality)? Why does Hanly not acknowledge what I believe has become mainstream thought in contemporary Freudian psychoanalysis: that we no longer bracket counter-

transference as some invading force that must be kept under tight control? Why does Hanly seem to ignore the complexity of the issue?

I can think of two possibilities. One, that his paper is an implicit argument against what he sees as the excesses of postmodern thinking. Here I think Hanly may be responding to the semantic connotations of terms. Certain terms are so embedded within theoretical assumptions that it is difficult to think about what they mean without thinking of their surplus meanings. So the reader of an analyst who writes about conflict around aggressive drive derivatives will assume that the writer is coming from the perspective of modern conflict theory, and the reader will be more or less receptive to the information based on what the words *drive derivative* connote to him. In the same way, when we read about how reality may be "constructed"—or, in this case, when we read of irreducible subjectivity—then we assume the writer speaks from a relational, postmodern perspective, and we are more or less receptive to what we read based on what we think of this perspective.

Now let us consider Arlow (1969). In his classic paper on unconscious fantasy, he introduces a fundamental, "classical" Freudian concept: that our perception of the world is colored by the filter of our unconscious fantasies. Can we attempt to make our inner filter more clear and "objective"? Of course—that is one goal of psychoanalysis. But how successful can we be, ultimately? Classical Freudians have addressed this issue: Brenner (1994) writes that *every* aspect of mental functioning is a compromise formation. This means—as Rothstein (2005), another leading "classical" Freudian theorist, points out—that every analyst is *inevitably* compromised in his perceptions. We can aspire only to relative objectivity.

Here we have major "classical" Freudian analysts questioning the concept of the objective analyst, with one, Rothstein, using this as a bridge to a Freudian theory of intersubjectivity. How is this idea that, to some degree or another we always "construct" reality, despite our best efforts to minimize our subjectivity, substantially different from the idea that our perception of the world is irreducibly subjective?

I am here assuming that, in the latter concept, we agree that there is, in fact, something real out there that we try to perceive as accurately as possible. I believe that there is similarity between the concepts, but

one indicates allegiance to a particular psychoanalytic group and its assumptions, while the other indicates allegiance to a different group and its assumptions. Thus, Hanly may be attempting to defend one version of Freudian thought from what he sees as an incompatible version of (and critique from) relational thought.

I also think that Hanly knows the literature I have cited and has a different view of what *subjectivity* refers to. I have been using a broad definition of subjectivity, while my hunch is that he is using a more specific and narrow definition of subjectivity. Unfortunately, he does not define *subjectivity* or *irreducible subjectivity,* but he seems to use the former to mean circumstances in which our observation of data is "unavoidably subjectively compromised" (p. 903). He seems to see it as the opposite of critical realism. He writes, as I quoted earlier:

> Contemporary psychoanalysts of the subjectivist school will assert, contrary to critical realism, that objective observation is an authoritarian myth and that thinking is irremediably a priori, since the mind has no alternative but to impose, in some Kantian-like fashion, the stamp of itself in the construction of everything it perceives or contemplates. [p. 903]

Later, he comments: "The problem is not with the criticism—namely, that some clinical observations of analysts are necessarily subjective—but with the assertion that all clinical observations are necessarily subjective" (p. 904). His objection, then, is to a view of subjectivity that cannot see the objective world and make accurate observations (and, certainly, to a view that denies the existence of a world outside the observer's subjective shadings). Thus, to the extent that an analyst or a scientist is able to know his subjectivity and bracket it in his observations, Hanly would have no problem.

Unfortunately, as I have discussed, it is not clear that subjectivity can be set aside in this way. Nor is it clear that Hanly's view of the relationship between observer and data is maintained even by "real" scientists (considering, for example, the Heisenberg principle, or Bohr's principle of complementarity).

Does this mean, however, that our observations of (ambiguous) data are necessarily doomed to be compromised, and that we cannot know

the "real" world? Must one be a critical realist in order to engage in this process of induction and deduction? I will return to this question later.

I have questioned one of Hanly's assumptions: that the process of psychoanalytic theory modification requires an epistemological position of critical realism. Let us now move to his hypothesis that psychoanalytic theory changes through a process of deduction and then induction, in the context of critical realism. Hanly attempts to illustrate his hypothesis through a discussion of turning points in Freud's theorizing. He tries to show how Freud's theory evolved based on the interplay of inductive and deductive factors.

Hanly begins this process with Freud's move away from the seduction theory. That theory predicted improvement when scenes of childhood seduction were recalled and affects associated with these events were abreacted, but this did not happen. Hanly writes that Freud revised his theory, his deductive hypothesis, in response to its not being confirmed by clinical observations. He notes: "Freud submitted to the impersonality and the sublime indifference of logic and fact to our wishes" (p. 906). This is critical realism in action. Freud then had to "save the appearances" (p. 906), in Hanly's words. Hanly first presents an example from astronomy, and then writes that Freud had to "save the scenes of sexual seduction disclosed by his clinical observations, scenes that his seduction theory took to be memories of real historical events" (p. 906).

He then goes through a sequence of logical possibilities from which Freud could have chosen to account for these scenes that he had taken to be actual memories. Through both his self-analysis and his clinical experience, Freud was able to "stumble" on a crucial "inferential step," as Hanly calls it (p. 907): that these "memories" of seduction were repressed infantile sexual fantasies. This hypothesis moved psychoanalytic theory to the topographic model.

Let us pause yet again. Hanly presents a lovely and clear example of how Freud's theory advanced based on scientific realism—that is, logical deduction based on hypothesis-testing in the clinical situation and modification of these hypotheses based on the interplay between hypothesis and observation, in which hypotheses are confirmed or disconfirmed. My question is this: while Freud's theory can be seen in this way, is this the path that Freud *actually* took as he revised his theory?

In other words, Hanly presents Freud as a logical scientist, completely rational (Hanly does not, as others might, see the role of Freud's self-analysis in modifying his theory as evidence of his subjectivity). Is this, in fact, how and why Freud changed his theory? Hanly presents no historical evidence regarding this issue that, it seems to me, is important. If one wants to think of psychoanalytic theory as changing primarily through the application of rationality, logic, and the scientific method, then one ought to demonstrate that, in fact, this is the way it actually happened (rather than showing that, after the fact, one can impose this idea of scientific progress on theoretical changes).

Schimek (1987), in a detailed account of how Freud's seduction theory evolved from 1896–1933, presents an account of changes that does not seem to go along with Hanly's hypothesis. Schimek disagrees with arguments, including a late account by Freud himself, that Freud changed his theory because he discovered that patients' reports of actual seduction were really fantasies, i.e., that new data forced Freud's change. Schimek (1987) writes:

> My main argument will be that Freud's conclusion that hysteria always requires the occurrence of sexual abuse in early childhood was not based directly on the patients' reports and conscious memories, but involved a great deal of selective interpretation and reconstruction. The reconstructions presupposed a complex set of hypotheses and assumptions and were based on a wide variety of not clearly specified data, ranging from thoughts, images, displays of affect and gestures, to specific memories from late childhood. By changing the original seduction theory, Freud did not suppress clear and unambiguous evidence; he only changed some aspects of his interpretation of the data—namely, their ultimate origin in an internal fantasy rather than an external trauma. [pp. 938-939]

Taking note of Schimek's account, we might again question Hanly's focus on the link between psychoanalytic theory and natural science, particularly as it relates to the nature of psychoanalytic data. The latter is always ambiguous, always filtered through differing theoretical and personal subjectivities and, as Schimek argues in the case of seduction theory, highly subject to inference and interpretation on the investigator's part.

One can question the degree to which induction (i.e., changes in theoretical hypothesis based on clinical "facts"), as opposed to deduction, was "primary" (and whether anything can be considered "primary" in this highly circular process). Certainly, Freud's move away from seduction theory was prompted by his clinical experience. But it was also affected by his shifting theoretical emphases.

When one compares Schimek's account of an evolving seduction theory with Hanly's, one sees Schimek demonstrating a more evolutionary change that has, as Schimek writes, "a far greater continuity than is usually assumed between the major aspects of Freud's thinking before and after the 'abandonment' of the seduction theory" (1987, p. 961). Hanly, in contrast, presents Freud making a logical, rational, and more clearly defined theoretical shift based on clear evidence. Further, and perhaps more to the point of Hanly's contention that Freud modified his theory in response to *different* clinical observations or facts, Schimek traces the way that Freud kept changing his theoretical inferences about the *same* clinical observations (or facts).

Can Freud's process of theoretical evolution be seen as a rational one involving the interplay of induction and deduction, as Freud looked at data that disconfirmed his hypothesis? The answer is yes, at one level of abstraction, and when the "facts" chosen relate to the degree of clinical improvement. But on that level of abstraction, virtually any development in scientific theory can be understood in this way, after the fact. Any theoretical change must account for data in some way. Yet this level of abstraction omits the theorist's day-to-day, year-to-year *process* of scientific change and discovery. It leaves out the role of accidental discovery, of synthetic creativity, of scientific imagination, of the personal nature of different individuals in choosing which data to consider most important and in coming to varying kinds of logical inferences when processing the same data. Hanly acknowledges Freud's "stumbling," but does not consider its implications for its role in Freud's revisions.

Hanly quotes Freud to illustrate his commitment to critical realism. Permit me to offer another sample of Freud's writing:

> *The Corner-Stones of Psycho-Analytic Theory.*—The assumption that there are unconscious mental processes, the recognition

> of the theory of resistance and repression, the appreciation of the importance of sexuality and of the Oedipus complex—these constitute the principal subject-matter of psycho-analysis and the foundations of its theory. *No one who cannot accept them all should count himself a psycho-analyst.* [1923, p. 247, italics added]

This is not the voice of a dispassionate scientific investigator; it is not the voice of someone who makes deductive hypotheses and changes them based on induction, with induction primary. Freud's was the voice of the leader of a new movement. He was someone who reasoned critically but within clear parameters, parameters that were determined a priori, based on political and theoretical beliefs about the true nature of psychoanalytic inquiry that were held and asserted with the same strength that religious believers assert their religious articles of faith.

Freud was quite clear about what data was considered acceptable to observe and consider. What was included or excluded from Freud's parameters must have affected what kinds of data he, as well as his followers (who wanted and needed his approval), observed and what kinds of data he and they felt were worth theoretical consideration and emphasis.

In Hanly's paper, there is a discussion of Freud's shift from the topographic theory to the structural theory. Here, too, Hanly presents Freud as a rational scientist who finds difficulty with the topographic theory and, through a process of logical reasoning that Hanly illustrates through logical syllogisms, arrives at structural theory. This, Hanly writes, demonstrates "the interdependence of inductive and deductive reasoning in scientific thinking" (p. 910). Again, Hanly presents Freud's shift as a move from one formulation of psychoanalysis to another that better fits the data.

But Freud did not clearly move from the topographic model to the structural model. As was his custom, he did not replace earlier formulations of his theory. He *added* formulations, so that old formulations lived on alongside the new. Thus, Arlow and Brenner (1964) wrote a monograph arguing against the tendency of psychoanalysts to use both topographic and structural theories; they would not have felt the need to write such a monograph if Freud had clearly abandoned the topographic

theory in favor of the structural theory. Further, if it was so clear to practicing analysts that the latter formulation was rationally superior to the former, then they would not be in a position of using both formulations.

In their introduction, Arlow and Brenner write:

> It is important to realize that the distinction between these two theories and nomenclature which marks that distinction are essentially matters of generally accepted custom and convenience. The structural and topographic theories were never named as such and presented by Freud in finished or "final" form. They are groups of related ideas within the area of psychoanalytic theory which have never been precisely delineated. That is, no one has ever said explicitly which parts of psychoanalytic theory prior to 1923 were to be included within the term "topographic theory" nor which parts after 1923 were to be understood as comprising the structural theory. It has simply been understood in a general way that each theory comprises a group of related ideas having to do particularly with the nature and functioning of what Freud called the mental apparatus. [1964, p. 6]

This blending of "theories," of the topographic and structural hypotheses, suggests that the process of Freud's theoretical revision is not as clear and as based on clinical evidence as Hanly asserts. Both sets of "related ideas" survive alongside each other because each helps the clinician focus on different sets of clinical data. They address different clinical questions.

Hanly then proceeds to his third example of how Freud modified his theory through the interplay of inductive and deductive reasoning. He provides a clear discussion of Freud's conversion theory of anxiety, its difficulties, and how these difficulties were resolved via Freud's introduction of the theory of signal anxiety. At this point, Hanly writes some surprising paragraphs that effectively overturn his thesis:

> Here there is no claim that Freud *actually* followed this course of deductive reasoning . . . . He states just the opposite: "It is not so much a question of taking back our earlier findings as of bringing them into line with more recent discoveries" (1926, p. 141) . . . . My assumption is that the discoveries to which Freud is referring are observational rather than conceptual. My point

> is that the hypotheses of Freud's theory are sufficiently rich, reality bound, and inferentially interrelated that theoretical reasoning, even without observation, can identify explanatory problems and indicate the direction in which a solution may be found, *even in the face of apparent observational confirmation of the theory that can be shown to be theoretically unviable. This truth about psychoanalytic theory does not depend upon its having been recognized by its creator.* However, everything happens *as though* Freud knew that his conversion theory of anxiety was, at best, so incomplete that its generalization produced a contradiction . . . . This *speculative reconstruction* calls our attention to certain *logical and rational functions of the economic unconscious.* [pp. 912-913, italics added]

Hanly is now telling us that this part of his paper ("here" presumably refers to the last example), which illustrates how Freud modified his theory based on a combination of induction and deduction, is based on a "speculative reconstruction." He no longer claims that this is how and why Freud *actually* changed his theory. No, this is how one can imagine how Freud's theory could have changed. It is "as though" Freud's theory changed through this rational process. It changed in this way even though Freud may not have known that he was engaging in this kind of rational thought process.

This is, perhaps, why Hanly provides us with no information about Freud's life—his battles with deviant thinkers, his political struggles, and how these might have affected his movement in certain theoretical directions and his refusal to consider other directions. As far as Hanly is concerned, these factors did not affect Freud's theoretical changes.

How does Hanly argue that rational processes alone influenced Freud's changes, whether or not Freud knew about these processes? Hanly introduces a new hypothesis in his paper, at the very end of his discussion. Hanly introduces the idea of a "preconscious critical function" (p. 913), perhaps part of the "economic unconscious" (p. 913). This function explains how Freud could know something without knowing it. The function "appears to be the byproduct of the acquisition of language and those experiences of practical successes and failures in reasoning that tutor us in the structure of reality" (p. 913).

In other words, to use Freud's terms, the development of secondary process thinking carries within it objective realism. However, as we all know, one main tenet of psychoanalysis is that secondary process thinking is not as logical as we believe it to be, and that it is heavily infiltrated, influenced, and often guided by unconscious process. Freud could easily have used the term *irreducible subjectivity* to describe this situation.

In summary, Hanly presents his paper as follows: Freud, working in the way of scientists in the natural sciences, modified his theory based on the interplay of deduction and induction, with induction primary. He did this while working within a philosophical fabric of critical realism. As I have gone through Hanly's paper, I have questioned many of the assumptions underlying his argument, including his conception of subjectivity; the nature of psychoanalytic facts and their relation to facts in the natural sciences; the question of whether Freud was following the data or was looking only at some data and not at other data, swayed by his theoretical convictions; and whether, in fact, Hanly is imposing a theoretical ideal on the more messy, actual process of theoretical change.

Hanly's paper idealizes rationality by comparing psychoanalysis with natural science; by introducing syllogisms that, Hanly says, guide our theoretical changes even though we may not know it; by its sole focus on induction and deduction as responsible for theoretical development; by ignoring the actuality of what was going on in Freud's life that may have affected both his hypotheses and his observations; and, perhaps most, by its treatment of subjectivity.

I would like to conclude my discussion with some brief comments on whether an attitude of critical realism is essential for the process of induction and deduction that Hanly describes. This issue also touches on the relationship between the theorist and his theory, and I will comment on that, too.

We can contrast Hanly's focus on critical realism and Renik's notion of irreducible subjectivity with Loewald's approach to psychoanalysis. Loewald (1960) argues against the model of analyst as scientist. He writes:

> The objectivity of the analyst in regard to the patient's transference distortions, his neutrality in this sense, should not be confused with the "neutral" attitude of the pure scientist towards his

> subject of study . . . . While the relationship between analyst and patient does not possess the structure, scientist–scientific subject, and is not characterized by neutrality in that sense on the part of the analyst, the analyst may become a scientific observer to the extent to which he is able to observe objectively the patient and himself in interaction. The interaction itself, however, cannot be adequately represented by the model of scientific neutrality. It is unscientific, based on faulty observation, to use this model . . . . What I am attempting to do is to disentangle the justified and necessary requirement of objectivity and neutrality from a model of neutrality which has its origin in propositions which I believe to be untenable. [pp. 18-19]

Loewald continues that it is closeness between analyst and patient (the patient's identification with his analyst, their "interactions") that facilitates an analytic process. It is not the analyst's scientific distance and objectivity.

I believe that this closeness is also the context for the process of observation and deduction. Our personal and intellectual involvement and commitment to a clinical and theoretical question helps us gain insight into a particular dimension of a patient. It guides our hypotheses and our observations. Freud's "subjectivity" facilitated the rational process that Hanly describes. Later analysts, with different personal and theoretical concerns, working in different psychoanalytic environments—analysts such as Klein, Winnicott, and Kohut—took a different path of induction and deduction. They discovered new "facts" because they attended to different aspects of their patients and because they understood these facts, *which had always been there,* in new ways.

I agree with Hanly that we are always balancing between inductive hypotheses and deductions. But we are also working in a context of subjectivity in which we make decisions about which data it is appropriate to utilize at any given moment. Gabbard (1997) writes of the constant interplay between an analyst's objectivity and subjectivity. He observes that "meaning is *both* constructed and discovered" (p. 24, italics in original). In the introduction to his paper, he states:

> I will offer a useful way of thinking about objectivity in a context that acknowledges the problematic nature of absolutism and the

> presence of two subjectivities in the consulting room. In short, there is a degree of objectivity in the analyst's subjectivity. [p. 16]

For Gabbard, the choice is not between "critical realism" and "irreducible subjectivity"; Gabbard acknowledges both the analyst's objectivity and his subjectivity, and sees the analytic goal as seeking "objectivity in an intersubjective context" (p. 21). I agree.

I want to thank Hanly for his clearly written argument and for raising an important issue in psychoanalysis.

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545 West End Avenue, 1A
New York, NY 10024

e-mail: andrew.druck@nyu.edu

Volume LXXXIII, Number 4

SOME QUESTIONS REGARDING REALITY, SUBJECTIVITY, AND PSYCHOANALYTIC THEORY CONSTRUCTION

BY BRUCE REIS

Keywords: Reality, subjectivity, analytic theory, Charles Hanly, Freud, critical realism, anxiety theory, Kant, perception, science, unconscious, reason, reality.

I would like to thank Dr. Charles Hanly and *The Psychoanalytic Quarterly* for the opportunity to engage with the multiple issues brought out by Hanly's paper, "The Interplay of Deductive and Inductive Reasoning in Psychoanalytic Theorizing." Several of the themes raised by Hanly represent central topics in the current practice and theory of clinical psychoanalysis. While I cannot address all these topics here with the degree of attention I would wish to, I would like to comment on some of what I regard to be key questions raised by Hanly's contribution.

I will begin with what Hanly describes as his "speculative reconstruction" (p. 913) of Freud's process of theory construction, and then consider the dichotomization of *critical realist* and *subjectivist* positions. I will assert that the presentation of pure positions is not tenable, and I will conclude with some thoughts regarding what I take to be implications of Hanly's view.

SPECULATIVE RECONSTRUCTION

Hanly's treatment of Freud's process of theory construction is a reading from the position that he identifies as *critical realism*. Hanly refers to his own speculative reconstruction of this process. He makes a rather con-

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Bruce Reis is a faculty member at New York University Postdoctoral Program in Psychotherapy and Psychoanalysis, and is a member of the North American Editorial Board of the *International Journal of Psychoanalysis* and the Editorial Board of *The Psychoanalytic Quarterly*.

vincing case from this position in describing the development of Freud's thinking in three major areas of theory: childhood and infantile sexuality, structural theory, and the theory of signal anxiety. He argues that Freud's use of deductive and inductive methods guided his explorations and conclusions.

Hanly also hints at the idea that these were not the only sources of influence in theory construction when he suggests, in his section on infantile and childhood sexuality, that negative outcomes forced Freud to reassess his theory, and that there were "other cogent reasons that Freud (1897) had for doubting his *neurotica*" (p. 906), which Hanly tells the reader he will "disregard" for the purposes of the present discussion.

Similarly, when discussing changes to Freud's anxiety theory, Hanly states that "despite phenomena that appear to corroborate it, Freud (1926) found it necessary to fundamentally revise it" (p. 910). Again, Hanly makes a convincing case that Freud followed deductive principles in understanding the need for such a revision and in making changes to the theory. But then he pulls back from his own explanation when he writes: "Here there is no claim that Freud actually followed this course of deductive reasoning. In fact, he states just the opposite" (p. 912).

The acknowledgment that Freud did not intentionally follow a path of deduction in revising the anxiety theory seems a serious disconfirmation of Hanly's speculative reconstruction. That Freud did not fully give up the conversion position until the 1930s further cements the contradiction. Hanly's answer to this problem is that Freud was not deductive *enough,* and had he employed more deduction, he would have made the change sooner or more completely. But that is different than arguing that Freud relied on a deductive (or inductive) method in making (or, perhaps more important, in *not* making) these changes.

In explanation, Hanly writes:

> My point is that the hypotheses of Freud's theory are sufficiently rich, reality bound, and inferentially interrelated that theoretical reasoning, even without observation, can identify explanatory problems and indicate the direction in which a solution may be found, even in the face of apparent observational confirmation of the theory that can be shown to be theoretically unviable. [p. 913]

Yet that seems to create another problem, for in the example of the *neurotica* (theory of the neuroses), we are told that Freud revised his theory in the face of disconfirmatory evidence, and in the example of the anxiety theory, we are told that Freud needed to contradict the confirmatory evidence because it created "explanatory problems" (p. 913). The process Hanly is describing when used in the social sciences seems to lead to a result we might better term *explanatory fit* than an objective truth arrived at via the happy marriage of inductive and deductive reasoning. Additionally, implicit in the process of gathering the "facts" that correspond to the real state of things is their arrangement into explanatory schemes, which introduces the issue of coherence.

Regarding the *neurotica,* one might ask what the other cogent reasons for doubt might have been. Does Hanly believe that these extend beyond those listed by Freud in his famous letter to Fliess dated the 21st of September 1897? For instance, there have been numerous reports that Freud was anxious and bitter about the reception his *neurotica* received, that he despaired about the effect of the presentation of his theory on his practice, and that he received the title of Professor after having given up the theory (see, e.g., Gay 1998).

Does Hanly believe these concerns played a part in Freud's theoretical revisions? Moreover, wouldn't Hanly agree that Freud's use of data from his self-analysis, especially including his dream life, constitutes a subjective element in his theory construction?

CRITICAL REALISM VERSUS SUBJECTIVISM

Hanly juxtaposes his position of critical realism with a position he terms *subjectivist.* The category is a huge container for all Kantian and post-Kantian approaches. By any measure, it is too large a grouping and creates serious problems in discussing real differences between theories. Into this category goes every post-Freudian psychoanalytic theory: all are "subjectivist" and therefore compromised when compared with the approach of critical realism. One need only reflect on who would be grouped together in this way (e.g., Klein; Bion; Lacan; all object relations, self psychological, and contemporary Freudian theorists, including Schafer and Loewald; interpersonalists, relationalists, and intersubjectiv-

ists as diverse as Renik and Ogden; as well as others) to understand some of the difficulties involved in Hanly's juxtaposing his view against those of nearly every other psychoanalyst who is not a critical realist.

Hanly's position is allied with the philosophical tradition of realism, which is the belief that there is an objective, material world that exists independently of consciousness and is knowable by consciousness. Bacon and Descartes are sometimes associated with this tradition, though Kant—while fond of referring to himself as an *empirical realist*—is not a realist to the realists. Kant acknowledged the existence of things independent of consciousness (*things-in-themselves*); however, he made clear his belief that we cannot have any knowledge of these things-in-themselves. Kleinian theory, and to a greater extent Bionian theory, is grounded in Kant's transcendental idealism and yields a version of reality and knowing based in dreamlike states rather than in clear and distinct ideas (Reis 2006).

THE FALLACY OF PURE POSITIONS

For purposes of exposition, Hanly presents his critical-realist approach and the subjectivist approach as internally consistent conceptually. I suspect, however, that—both in clinical practice and theoretically—in actuality there are not such rigid boundaries between these approaches. Indeed, the denizens of constructivism and postmodernism seem awfully certain that uncertainty, fluidity, ambiguity, and social construction are the way things *really are*. I suggest that, in this way, their positions are often implicitly mixed positions.

A similar observation may be made regarding Hanly's position of critical realism, which he juxtaposes with a subjectivist position that,

> . . . contrary to critical realism, [holds] that objective observation is an authoritarian myth and that thinking is irremediably a priori, since the mind has no alternative but to impose, in some Kantian-like fashion, the stamp of itself in the construction of everything it perceives or contemplates. [p. 903]

But this may not be the dichotomy that Hanly presents it as, for in his paper he describes a process he feels will minimize and control the

subjective element in perception and thought: "Hence, although objectivity is an achievement rather than a given, cognitive subjectivity can be *reduced* and, when it is, objectivity becomes *proportionately* more attainable" (p. 904, italics added). This suggests that, for Hanly, too, subjectivity is an always-present part of perception and thinking and cannot be entirely eliminated.

When Hanly goes on to state that the subjective element can be "overcome sufficiently" (p. 905) to allow us to operate in an objective manner, this necessarily implies that, for him, the subjective element remains, at least to some extent. The question that arises at this point is whether Hanly believes that when subjectivity is overcome sufficiently, it is somehow put to the side, allowing for nonsubjective cognition and perception; or whether he believes that the minimization of subjective elements allows for an objectivity that continues to retain subjective elements.

It is possible that Hanly is arguing that, having minimized the subjective element, what is left is nonsubjective, not clouded by the contamination of subjectivity. But that claim, in both its strong and weak forms, would seem to undo the entire ground of experience, for who does Hanly understand truth is being revealed to? There must be a subject of perception (Merleau-Ponty 1945), there must be a subject of reason and thinking (Descartes 1628), there must be a subject of the unconscious (Lacan 2006), and there must be someone who in the first place had an interest in finding truth, an intentional subject. Where does Hanly locate these subjects in his version of what happens during objective knowing?

It seems to me that there are two alternatives. One is to attempt to do away with the idea of subjectivity altogether in the creation of mind-spaces that are essentially subjectless and hence not compromised (which I do not really believe that Hanly is attempting to do here, from my reading of his paper). The other is to acknowledge that the dichotomy between critical realist and subjectivist positions is actually a far more complex relation than one of *opposing* epistemologies.

Sufficiently overcoming the subjective element in perception and thought is not an easy task, as Descartes demonstrated. Yet, interesting questions are raised in thinking about the elimination of subjective elements from perception or thought that began as subjective phenomena

(I understand that Hanly would likely say that they began *with* rather than *as* subjective phenomena, and if so, herein would lie a difference in our views).

One such question is, what would be left if we were able to perform such a procedure of eliminating subjective elements? The realist would seem to argue that what is left when one strips away subjectivity is objective thought and perception about the way things really are. Of course, there have been other approaches to constructing the category of objectivity within psychoanalysis (Reis 2011).

It is unclear whether Hanly views humans as having a native rationality. At one point, he seems to affirm this by writing of a "savoir-faire" that people appear to simply have, one that stems from "a reflexive critical function" (p. 913). This capacity is not infallible, he tells us, but at the same time, he finds it "remarkable that this logical, evaluative function is as reliable as it is" (p. 914). It is a capacity that Hanly augments elsewhere in his paper by describing the power of our "unaided observation that allows us to acquire commonsense knowledge of other persons and other things" (p. 903). But these faculties are denied the status of an a priori; indeed, they must be denied this status if Hanly is to remain a realist and not become a Kantian. I would like to know how he conceives of these capacities if they are not inborn.

Hanly suggests that it is only by linking these capacities just described to formal reasoning processes that humans may "correct" their understandings of the world and others in it. Indeed, he sees the development of logical systems of thought as representing "the dominant paradigm shift of civilized life" (p. 904). Yet it seems reasonable to me to conjecture that we may train a person to view the world in most any way we wish. We could, for instance, train an analyst to be a stellar Kleinian and to view the world according to the particular ideas that Klein proposed regarding one's access to other minds, the ways in which an individual may affect other individuals, and the great drama that occurs within the intrapsychic theater. We could "correct" that individual when he veered from this view of human beings by restating the tenets of the Kleinian view and pointing out how his understandings adhere or fail to adhere to those tenets, as illustrated in his clinical process notes or by changes in the patient's condition. We could do this to the point that

the individual predominately understood his own functioning and that of others from this perspective.

Indeed, we could do this so well that the analyst could become successful in treating patients. He might then take this success as proof of the validity of Kleinian theory. But while the analyst might "see" evidence of unconscious phantasies, for instance, that does not mean that they exist in an ontic sense.

We would like to argue differently for science. We would like to say that it indeed provides us—with certain reasonable degrees of error—with a view into the real state of things. But science, too, is a view on things.[1] Thus, I read the quotation from Einstein that Hanly uses early in his paper to reflect a similar sentiment to the one I have just expressed: "The only justification for our concepts and system of concepts is that they serve to represent the complex of our experiences; beyond this they have no legitimacy" (Einstein quoted in Hanly, p. 899).

This brings me to a final comment before my conclusion. My reading of Hanly's paper raises questions for me regarding his extension of the critical-realism approach to mental phenomena. Specifically, in my reading, he appears to approach unconscious psychic operations as if they followed the rules of syllogistic logic. I may be mistaken that this is his contention, for he nowhere explicitly states this, but phrases such as "this speculative reconstruction calls our attention to certain logical and rational functions of the economic unconscious" (p. 913) give me that indication.

From there, and as I mentioned earlier, Hanly goes on to describe the rather remarkable powers of evaluative logic that the preconscious possesses. The unconscious and preconscious minds begin to look as if they operate according to the rules of formal logic and employ logical, evaluative capabilities with regard to the world. All this feels very predictable, very scientific, until I remind myself that Hanly is writing about the Freudian unconscious, and then his certainty begins to feel rather counter to what I have always regarded as an unknowable area of human experience that operates according to rules very much outside the realm of formal logic and reason (Matte Blanco 1998).

[1] By writing that science is a view on things, I do not intend to completely dispense with it, as some more radical analytic viewpoints have. I merely wish to situate science among the various perspectives on knowledge and experience that analysts employ.

Hanly attributes to Freud the attitude that "the human psyche is part of nature and as knowable as any natural object" (p. 903). But I find myself missing the feel of affect, idiomatic meaning, and association that give the Freudian unconscious its quality of ineffability, mystery, and great power. It seems a contradiction in terms to suggest that we can know this area we have called the *unconscious,* for it is all but definitive that its status should be uncertain. "After all," wrote Bollas (1999),

> . . . how far can consciousness go in its effort to comprehend the unconscious? Not so very far after all, particularly when both analyst and patient so often find thrills of understanding destroyed by new material, which sends them both packing, the one to free associative breakage, the other to evenly suspended attentiveness. [pp. 27-28]

CONCLUSION

There are many ways to be Freudian these days (e.g., Bollas 2007; Diamond and Christian 2011; Druck et al. 2011). Hanly, too, is particular in the way he is a Freudian. In utilizing the terms *reality, objectivity, empiricism,* and *rationalism* with reference to the mind and the clinical situation as he does, Hanly attempts to stay extremely close to his reading of the Freudian text and not admit later developments (an approach reflected in his reference list). Thus, Hanly's argument is not affected by the series of stinging critiques made by philosophers of science who have challenged the scientific basis of psychoanalysis and the truth claims it makes (e.g., Cioffi 1998; Grunbaum 1984; Popper 1960). Nor is his argument moved by developments in clinical epistemology such as the hermeneutic turn (e.g., Bernstein 1983; Gadamer 1975; Ricoeur 1981), the postmodern turn (e.g., Derrida 1976; Foucault 1973), or, for instance, the psychoanalytic relational turn (e.g., Greenberg and Mitchell 1983). This preeminent professor of philosophy who is also a trained psychoanalyst, knowledgeable of all these developments, cleaves to one Freud, the scientific Freud—not the one who loved and quoted Goethe or the one who delighted in jokes and the theater and used them to illustrate and inform his thinking. Hanly's interest is in the power of reason, not the power of unreason.

It is through such reason, he believes, that the analyst can be provided with objective truths. Like the Freud who wished to "furnish a psychology that shall be a natural science" (1950, p. 295), Hanly has the goal of developing a psychoanalytic science that, even if it lacks elements of certainty, can make truth claims about the nature of reality, as well as about the reality of the human psyche. He is not saying that psychoanalysis gives us good insight into—or even a very reasonable idea of—reality, or of someone's mind, but that it reveals the nature of those phenomena as they are—that is to say, the real state of things. This is a very bold claim in this day and age.

To me the position of critical realism seems out of place in the present atmosphere of psychoanalytic pluralism that has been in the process of forming during the last twenty years, approximately. To get along in this new climate, analytic schools have begun tolerating the differences among themselves, still disagreeing and sometimes vehemently so, but engaging each other much more, and in the process sharing perspectives and inevitably changing as a result.

Indeed, as a consequence the whole idea of analysis, it seems to me, has gone through some rather major changes in recent decades. It is unclear to me whether critical realism can exist in this space, for it seems an orthodoxy that brooks no dissent: one either agrees with the facts as they are understood by critical realism, or one is wrong. There does not seem to be much space for other perspectives, different views, or innovation.

Perhaps I have already created the dichotomization I have been striving to avoid by placing critical realism outside the group of psychoanalytic theories that can interact with each other. Yet, to the extent I am able, I have instead sought to ask questions of Hanly from a perspective that seeks to minimize apparent discrepancies. I do not expect that he will agree with much of what I have suggested, but I look forward to his participation in the questions themselves.

Acknowledgments: The author expresses his gratitude to Drs. Phillip Blumberg and Steven Ellman for engaging with him in generative conversations on topics related to this paper.

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205 East 16th Street
Suite 2C
New York, NY 10003

e-mail: bruce.reis@nyu.edu

Volume LXXXIII, Number 4

SKEPTICAL REFLECTION ON SUBJECTIVIST EPISTEMOLOGIES

BY CHARLES HANLY

Keywords: Psychoanalytic theory, epistemology, philosophy, subjectivity, objectivity, alternative perspectives, countertransference, Kant, science, critical realism, Loewald, Oedipus complex, neutrality.

I am pleased to respond to the comments of Druck (2014) and Reis (2014) on my paper, "The Interplay of Deductive and Inductive Reasoning in Psychoanalytic Theorizing," of which the primary focus is an exploration of deductive reasoning in psychoanalytic theory. It is a companion piece to an earlier paper (C. Hanly 1992). It is an affirmation of the fundamental place of observation and inductive reasoning—facts of observation and inferences from them—in psychoanalytic knowledge, without which theory remains too conjectural and speculative.

Epistemology is the theory of knowledge. It includes questions of the reliability and generalizability of clinical observations in psychoanalysis, such as the question at the extreme end of the spectrum of whether or not there is such a thing as a clinical fact to observe. However, the importance of epistemology as a philosophical discipline can be exaggerated, insofar as clinicians may work as critical realists while espousing some form of subjectivist epistemology.

I shall argue in what follows that at least some psychoanalytic epistemologists are inconsistent subjectivists or inconsistent objectivists. An analyst who is working for the most part by relying rigidly on received, preferred ideas—rather than being receptive enough to the patient to test his preferred ideas against the actual experience, memories, fanta-

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Charles Hanly is a Training Analyst of the Canadian Psychoanalytic Society and Professor Emeritus of Philosophy, University of Toronto.

sies, conflicts, and motivation of the patient that are repeatedly available in observation of associations and transferences—may think that he is a realist because of his own unconscious, unresolved veneration of the source (e.g., an analytic school, personal analyst, or supervisor) of his preferred ideas. Such an analyst would qualify as an inconsistent objectivist—philosophically committed to realism but practicing subjectivism.

I agree with the arguments of Druck and Reis that such an analyst is in need of what I would call *trial alternative perspectives.* Whether or not an analyst is able to be objectively understanding of his patients is not determined by the epistemology explicitly espoused (Canestri 2006); it is determined by his receptivity, sympathy (empathy), knowledge, experience, countertransferences, and the like. Adopting an empiricist (objectivist) epistemology no more guarantees the analyst's objectivity than does the knowledge that the earth's diurnal rotation on its axis causes a person to no longer see the sun moving from east to west. We need ideas in order to observe our patients and the meaning of their words and behavior, but we also need to be sufficiently receptive to patients to be able to allow what we observe to correct our ideas about them (C. Hanly 1995).

In the discussion of these epistemological questions, it is useful to pay attention to the meaning of key words *subjective, subjectivity,* and *subjectivism,* and to their opposites—*objective, objectivity,* and *objectivism.* I have utilized the definitions found in the *International Webster New Encyclopedic Dictionary* (1975) and the *Shorter Oxford English Dictionary* (1952). In particular, we should not be confused by the fact that there is a dictionary definition in which subjectivity is a universal characteristic of human psychic life. Our psychic lives are largely hidden in our heads because that is where our brains are, and—apart from an individually variable but rather rich array of behavioral and expressive communication of beliefs in action, emotions, attitudes, likes, dislikes, attractions, and aversions—we remain highly dependent on language to let others know what we believe, feel, think, imagine, dream, etc.

I wonder if it is not sometimes this natural, inevitable subjectivity in the sense of the interiority of the mind—which has been called *psychological* or *ontological subjectivity* (C. Hanly and M. Hanly 2001), in order to differentiate it from *epistemological subjectivity*—that some analysts

have in mind when they speak about the subjectivity of the analyst. In this psychic meaning of *subjectivity*, all mental processes are subjective, including the clinical use of ideas that guide our interpretations but that we keep to ourselves in clinical work. But, from the fact that mental states, processes, and contents are irreducibly subjective (ontologically) *psychologically*, it does not follow that they are irreducibly subjective *epistemologically*. Confusion of the two distinct meanings can make epistemological subjectivism seem more convincing than it is and can result in a disregard of its philosophical and theoretical problems.

Druck attributes this semantic confusion to me when he asserts that I imply "there is inevitable subjectivity, but this can be 'overcome sufficiently' to allow the analyst to make relatively objective observations that he can use to modify his theory" (p. 921). I do think that psychological (ontological) subjectivity is inevitable, but also that it cannot be overcome; it remains even as we communicate our feelings gesturally, behaviorally, and in words to others. It is *epistemological* subjectivity that can be sufficiently overcome for us to be able to observe others without altering them in making the observation—by causing them to be more as we think ourselves to be than they actually are. This distinction was clarified in an earlier paper (C. Hanly and M. Hanly 2001).

This semantic confusion is also evident in Druck's previous paragraph: "Hanly believes that, of course, we need to continually test our observations against our countertransferences (thus acknowledging the pull of inevitable subjectivity)" (pp. 920-921). Inevitable psychological subjectivity is ongoing; it is not "correctible," but this fact has no bearing on *epistemological* subjectivity. Unconscious countertransferences have a potential for causing epistemological subjectivity in the analyst, but this effect is not inevitable because their influence can be modified, and they may become useful aids to understanding the patient—especially when the wants bound to the fantasies have ceased to clamor for satisfaction in the analyst. An unconscious countertransference, caught sight of, can bring with it the cognitive benefits of recovered memories of traumatic experiences that can facilitate the formation in the analyst of broader empathic horizons and receptive sympathy for the patient's suffering, as well as indications of directions for speculations about its causes. This

epistemological and technical point has often been discussed in our literature.

This confusion concerning my use of *subjectivity* appears to be at the root of Reis's claim that I have made subjectivism into "a huge container for all Kantian and post-Kantian approaches" (p. 941). Reis writes that:

> Into this category goes every post-Freudian psychoanalytic theory: all are "subjectivist" and therefore compromised when compared with the approach of critical realism. One need only reflect on who would be grouped together in this way (e.g., Klein; Bion; Lacan; all object relations, self psychological, and contemporary Freudian theorists, including Schafer and Loewald; interpersonalists, relationalists, and intersubjectivists as diverse as Renik and Ogden; as well as others) to understand some of the difficulties involved in Hanly's juxtaposing his view against those of nearly every other psychoanalyst who is not a critical realist. [pp. 941-942]

If "post-Kantian approaches" refers to philosophy generally, Reis would be claiming incorrectly that I think empiricist philosophers such as Mill, as well as Oxford ordinary-language philosophers, advocate subjectivist epistemologies. Therefore, I shall assume that Reis refers to the post-Kantian German idealism of Fichte, Schelling, Hegel, and Schopenhauer. But whereas Kant (1781) rejected any dialectic of pure reason, Hegel (1816) reaffirmed the power of pure reason to know Reality and espoused dialectical logic, in order to grasp the structure and dynamic of Absolute Spirit, Hegel's name for a spiritual, ultimate Reality.

In opposition to Kant's critique of pure reason, Hegel's metaphysics and epistemology were a form of Platonic realism. Kant's (1781) categories of the understanding and the pure forms of intuition, space, and time are subjective in the sense that they are a priori (imposed by the mind on all sense experience and thought) and not derived a posteriori from experience (the reason for Einstein's criticism of a priori thought).

There is a sense in which Kant might have called himself a partial empiricist. Kant expressed his gratitude to the British empiricist philosopher Hume for awakening him from his Wolffian dogmatic slumbers, but he was not fully aroused. The crucial fact is that post-Kantian empiricism, both philosophical and scientific, postulates—for good reasons—

that space, time, and the categories of understanding, such as causality and subject-attributes, are based on properties of things and processes that we derive from sense experience. Any classification of philosophical theories that I would subscribe to would have to take these real differences into account.

The assumption that I classify almost all psychoanalysts as subjectivists is also incorrect. I do not think that Klein and the Kleinians are subjectivists, nor are most North American and European Freudians. British object relations theorists, for the most part, are realists; Kohut and the Kohutians are realists, in my opinion, but with some qualifications. Although I might be in error in thinking that, probably, most analysts are realists, such is my conviction based on reading the clinical material of epistemologically diverse analysts.

Moreover, I would not classify either Renik or Schafer simply as subjectivists, but rather as *inconsistent* subjectivists. They are subjectivists in their explicit epistemologies and critical realists when they write up case histories. This point has been made concerning Schafer's concept of narratology (M. Hanly 1996). Similarly, Goldberg (1976) has used subjectivist epistemological ideas to explain why Freudians see evidence in patients of an Oedipus complex caused by drive development, whereas self psychologists see evidence of parental narcissistic failure, but Goldberg's analytic work as gauged by his case descriptions and explanations suggests (at least to me) that he is seeking to give an objective account of the lives, the neuroses, and the analyses of his patients.

Let us briefly test Druck's claim that a belief in Arlow's subjectivist thesis enables the analyst to be more objective:

> I think that an analyst who is consciously and unconsciously trying to "overcome" his countertransference (which, by traditional definition, is inevitably unconscious and cannot be readily known) is *less* capable of "objectivity" than one who tolerates and holds his subjective reactions and uses them as data. The latter analyst, less defensive, is more capable of objectivity. [pp. 924-925, italics in original]

First, using subjective reactions as data to explore the interaction between analyst and patient is critical realism. However, if the underlying

premise is that all perception and thought is always sufficiently influenced by unconscious fantasy to render them so subjective that they no longer represent the object well enough to make a telling interpretation, then it could be said that Arlow is an epistemological subjectivist. If the premise is that this happens sometimes, and when it does, it renders observation deceptively convincing that it is objective when it is actually subjectively distorted, then certain indications may show a requirement for self-analysis, a return to analysis, or the prospect of a limited or damaged analysis.

I suppose that some analysts who remain too given to self-righteousness may defensively deny indications of shortcomings by protesting their realism, and fail to seek to remedy whatever their limitations might be. Such analysts would fall into the category of the inconsistent objectivist (see the foregoing) in relation to such indications of analytic inadequacy. However, the comparison should also be made with those who go beyond tolerating their shortcomings as analysts and take constructive steps to improve. Self-toleration may be better than denial, so long as it is not complacent but is only the first step in the direction of remedy by means of self-analysis or further analysis.

In psychoanalytic case studies, most interfering countertransferences are seen to involve prolonged, intense affective responses to the patient. The crucial point is that, in principle, there is a remedy for the analyst. The first interpretation of Arlow's epistemological premise (unconscious fantasies always render clinical observation subjective) rules out possible remedy. The first premise generates the problems of a subjectivist epistemology, while the second does not. The second interpretation, with the crucial modification of *sometimes,* rather than *always,* is critical realism. There are no disagreements, or, if there are any, they are technical issues concerning the waxing and waning of unconscious fantasies and the defenses deployed against them, and how and to what extent unconscious fantasies inhibit understanding of self and other. The same analysis applies to the epistemological implications of Brenner's compromise thesis. The underlying issue is the question of *all* or *some, always* or *sometimes, must* or *can,* and other, similar oppositions.

Druck quotes Loewald's observation that an adult son does not see his father as he did when he was a child. One could cite several such

shifts as a child's observational and reality-testing capacities strengthen, as the animism of childhood thinking recedes and the need for the use of adults as auxiliary egos declines. Who would disagree? These are reliable facts about individual psychic development. We are aware of these changes in ego functioning in ourselves, and we observe them in others. Who would doubt that changes of this sort help analysts to be more discerning clinicians, i.e., epistemological realists—not just in theory (philosophy), but in clinical practice?

But the inference to epistemological subjectivism does not hold. These developments in psychic functioning enable individuals to strengthen their capacities for subject–object differentiation, which is the platform on which reality testing is built. These developmental changes certainly take place in the subjective life of the individual, facilitated by good parenting and education. And they are subjective in the sense of being *psychologically* subjective (C. Hanly and M. Hanly 2001), but there are no grounds for inferring that these developments could leave individuals trapped in their own minds—that is, limited cognitively to *always* modeling others and the world upon themselves. On the contrary, they enable individuals to become aware of differences among people and between themselves and others.

Let us take into account that Loewald (1979) also affirmed the continued activity of the Oedipus complex throughout life: "In adolescence the Oedipus complex rears its head again, and so it does during later periods in life, in normal people as well as in neurotics" (p. 753). Loewald was making a generalization about people's lives. Druck quotes Loewald's (1960) distinction between "new discovery of objects" and "discovery of new objects" (p. 18), which formulates a critical-realist idea, insofar as Loewald's generalization is not about a new object created by analyst–analysand interaction, but through observations of a resurgence of an old object during the stages of adolescent and adult life, the Oedipus complex—which, according to Loewald's clinical evidence, has an extended waning that was not fully appreciated by Freud. His "new discovery" about the waning of the Oedipus complex is explicitly intended to correct certain of Freud's statements about the Oedipus complex because it more adequately corresponds to psychic reality.

Druck draws a clinching quote from Loewald: that the "analyst may become a scientific observer to the extent to which he is able to observe objectively the patient and himself in interaction. The interaction itself, however, cannot be adequately represented by the model of scientific neutrality" (Loewald 1960, pp. 18-19). It would indeed be an error to suppose that the analyst's personal responses to patients and their transferences are scientifically neutral in the sense of indifferent and without affect. Evolutionary biologists are not subject to negative transferences from the fossils they are studying.

But surely it would be unjustified to say that an analyst who picks up on a patient's sadness, even when disguised by her being superficially upbeat, must not experience any sympathetic appreciation of the patient's sadness in order to be a reliable (scientific), clinically neutral observer. It would be unjustified to claim that such a sympathetic reaction would disable the analyst's ability to confirm or disconfirm the authenticity of the patient's affect and the reliability of his own interpretive surmises by attending carefully to the patient's responses to interpretations.

It would also be unjustified to claim that such an analyst could not remain uncertain when the patient's responses to the interpretations warranted doubt. Critical realism does not require affectlessness on the part of the analyst as a requisite for objectivity in sensing a patient's affective state. The crucial questions are: What is the dominant affect of the patient? Is the analyst's affective response appropriate? What use does the analyst make of it?

I agree with Druck and Loewald that this monitoring-third activity of the analyst can be reliably carried out. I would only add that the affective responsiveness to the patient, while in need of critical assessment by the analyst like anything else, does not, in principle, render clinical observation subjective. On the contrary, the analyst's affective responses to the patient often contribute to objective knowledge of the patient that is essential to therapeutic work, no less than does the analyst's observation of the interaction.

Loewald (1960) accurately articulated the position of critical realism when he affirmed the analyst's ability to "observe objectively the patient and himself in interaction" (p. 18). (See also C. Hanly 2004; Hanly and Nichols 2001.) It seems to me that the meanings of *objective* and *subjec-*

tive that Loewald was using are similar to those that I have used, whereby *objective* means *belonging to the object of thought,* and *subjective* means *belonging to the thinking subject.*

In the clinical instance we have been considering, a latent sadness is thought by the analyst to belong to the object; sympathy for the sadness and the idea that it is left unattended by the patient's exaggerated and effortful enthusiasm belong to the thinking and feeling subject: the analyst. (The patient discovered her sadness through grief and mourning and their relation to a despairing anger that caused her to be unable to go onto the balcony of her high-rise apartment, and through becoming aware of the depth of her fatigue.) These are examples of meanings rooted in the psychic lives of patients and analysts and reflected in ordinary language, used in philosophy and science and recorded in dictionaries (e.g., *subjective:* "belonging to the thinking subject rather than to the object of thought: opposed to *objective*" (*International Webster New Encyclopedic Dictionary* 1975, p. 975).

Critical realism does not require that the relationship of the analyst to the patient be scientifically neutral in the sense of unfeeling, but only that, despite its not being scientifically neutral, the analyst is able, often and well enough, to function as a third (C. Hanly 2004). As Loewald put it, the analyst "may become a scientific observer to the extent to which he is able to observe objectively the patient and himself in interaction" (1960, p. 18), as quoted by Druck. I state the conclusion of this discussion hypothetically. If Loewald were an epistemological subjectivist, then my conclusion would be that his position is one of inconsistent subjectivism. Otherwise, I would suppose him to be a critical realist with a penchant for dramatic, insightful articulations of obstacles in the path of good psychoanalytic work.

I have mentioned Renik (1993) because of his clear and detailed—although mistaken, I think—arguments based on his conclusion of the *irreducible subjectivity* of clinical psychoanalysis. If, in the expression *irreducible subjectivity, subjectivity* refers to *psychological* or *ontological* subjectivity, then it is tautologically true, for we are subjects who are psychological, but if it is an affirmation of the irreducible *epistemic* subjectivity of clinical observations in psychoanalysis, then it is the statement of a

basic premise of philosophical subjectivism (see C. Hanly 1999; C. Hanly and M. Hanly 2001).

Druck is mistaken in his assertion that I have "confounded" the question of biased observation with the ontological question of existence. Neither Renik nor I, despite differences concerning psychoanalytic epistemology, has ever doubted that other persons, the solar system, and the universe exist, or that natural science has gained knowledge of them by means of observation. No such idea can be inferred from the claim that the analyst's clinical experience is irreducibly subjective. Renik's *epistemological* idea of irreducible subjectivity is not compatible with scientific realism, as far as clinical psychoanalysis is concerned, but it does not follow from the epistemological thesis that the existence of clinical patients is in doubt; the subjectivist thesis denies only that they can be known as they are in and for themselves.

The expression *irremediably subjective* means *incapable of being remedied or repaired* (*International Webster* 1975), *does not admit of remedy, cure or correction* (*Shorter Oxford* 1952)—not on the basis of some strawman definition of my own for the purpose of argument, but by the best of our standard dictionary definitions. However, Renik (1998) offered a remedy for irremediable epistemological subjectivity. The remedy is the use of *predictions* of the effects of interpretations on the functioning of patients. This method was used by Freud to test the seduction theory—the first psychoanalytic outcome study.

However, predictions are only of avail for this purpose if the observations that are made to test them are not influenced by the predictions or the point of view on which the interpretations were based. Making predictions does not magically remedy the irremediable. The repair does not work unless it repairs the factors causing the irremediable subjectivity. How would making predictions, for example, enable the observer to be equally accepting of confirming and disconfirming observations?

And if clinicians can make observations that are objective when they are looking for evidence for or against predictions validly inferred from interpretations, then these observations contradict the epistemological premise that all clinical observations are irremediably subjective. Clinical observations that confirm or falsify predictions are objective. I agree with Renik (1998) that psychoanalysis can predict as well as retrodict; but

realistically, I would rather say that it *can be objective,* for there is an ever-present danger of looking only for what would confirm a prediction, and of avoiding what would falsify it and hence the interpretation and the theory implied by the interpretation.

However, if the prediction argument is sound and valid, then logic requires the epistemological theory to be modified from the statement that *all clinical observations in psychoanalysis are irremediably subjective,* to *some clinical observations may be subjective and some may be objective.* But this is a statement of critical realism!

Similar reasoning applies to the subjectivism of Schafer. Schafer correctly points out that a patient's story can be influenced in the telling by what the patient thinks the analyst wants to hear, or by the fear of what the analyst will hear and might think, and thus, involuntarily and without design, the analyst exerts an influence on what the patient tells. But this routine clinical factor, which is usually corrigible, is made into an epistemological theory by being generalized to all clinical processes by Schafer (1981), with his assertion that "reality is always mediated by narration . . . . Far from being innocently encountered or discovered, it is created in a regulated fashion" (p. 45).

We can agree that reality is not "innocently encountered" in the search for knowledge (C. Hanly 1999, p. 439). However, the *always* of *always mediated by narration* is Schafer's generalization (not mine), which leads the way to the subjectivist epistemological statement that follows. If Schafer's narratological point is treated as a heuristic caution, then by being mindful of the influence of the listener on the narrator, the analyst *may* be able to better understand and interpret resistances in the patient's transference based on the patient's need to please and the fear of what he may have to say.

It is important to recognize that psychoanalysis is different from other observational sciences because the observing analyst is also the instrument by which the observation is made. But the purpose of the *critical* in *critical realism* is to acknowledge that difference. And, as Loewald (1960) notes, the analyst's use of his reflexive capacity as a third to observe the interaction between analyst and patient enables the analyst to be a scientific observer. Perhaps the gulf between the anatomist's observations (Harvey; see C. Hanly 2014) and clinical observations in psycho-

analysis is not as wide as Reis and Druck seem, at least in some respects, to want to have it.

I would add only this: that the analyst's reflexive awareness enables him, well enough and often enough, to differentiate what in the interaction is owing to the analyst and what to the patient—a differentiation that is fundamental to objectivity (Cavell 1998; Hanly and Nichols 2001). The issue of the logical distribution (*some* or *all, sometimes* or *always,* etc.) of the fundamental epistemological principle that *clinical observations are subjective* is the basic difference between epistemological subjectivism and critical realism. It is the claim of universality that generates the dichotomy.

In the philosophy of science, a distinction is made between methods of discovery and methods of proof. Methods of discovery can include anything that enables the theorist to formulate an adequate hypothesis. A philosophy colleague joked that being inspired to form an idea by reading *Alice in Wonderland* is acceptable so long as the idea is verifiable—i.e., that there is a method for finding evidence that would show whether it is true or false (Freud 1915). It is the verifiability of a hypothesis that is essential to its scientific or scholarly worth (C. Hanly 1970).

I believe that psychoanalytic interpretations are, for the most part, descriptive or explanatory hypotheses even when not grammatically expressed as such, a view I share with Renik (1998). It seems to me that Reis and Druck are critical of my paper because, given its subject; it does not take up the topic of the analyst as a source of interpretations. On this point, I am in agreement with them. The analyst's subjectivity, as distinct from his externally acquired knowledge, can be a fertile source of ideas for testable interpretations, according to the method of discovery. But in our daily work, we do not and should not exempt these interpretations from the requirement of evidence. We are attentive to what follows in the patient's associations and transference and to changes in functioning within and outside the analysis. The method of proof requires that these, like other interpretations, be tested against the effects that the interpretations are having on the functioning of the patient.

This observational activity of the analyst searches for evidence of the soundness or not of the interpretation(s), and hence of its objectivity—its being about the patient and not the analyst. The problem I have with

the claim that analysis is a co-creation, for example, is that the work of analysis is thought to consist of an analyst and patient developing a coherent, mutually agreed-upon co-creation of the meaning of the patient's life, which leaves out of the picture the critical matter of the correspondence of the co-created history with the patient's real life (Eagle, Wolitzky, and Wakefield 2001; C. Hanly 1999; C. Hanly and M. Hanly 2001). The meaning of a life invests the life of the person living it. I agree that co-creation occurs, but when it is asserted on principle that it must always occur, the possibility of carrying out the requirements of the method of proof is negated.

Much of what Reis and Druck have written on behalf of subjectivism falls within the method of *discovery* as distinct from the method of *proof*. The door against which they have enthusiastically but rather recklessly thrown themselves, without first looking at it, was never closed. I recently made the following statements:

> To know the atomic structure of a molecule does not depend upon self-knowledge; to know a patient does. In order to know our patients with realism and compassion, analysts need to be able to recall their own memories and phantasies that parallel the memories and phantasies of our patients, and which are causing their painful inhibitions, symptoms, neurotic anxiety, and depression. [C. Hanly 2013]

The associations, transferences, and behaviors of patients have to make a passage through the analyst's psyche via affects and aroused memories and fantasies, from the senses to thoughts and interpretations aimed at improving the patient's self-understanding and psychic functioning. However, the objectivity of the analyst's interpretations—the extent to which they tally with what is going on in the patient—is unavoidably grounded in the object (the patient), not merely in the subject (the analyst).

What the analyst communicates of his own affective responses in the interpretation when it is appropriate to the patient's affective state is likely to enhance the therapeutic efficacy of the interpretation, and when not, then not (C. Hanly 1994). The subjectivity of the analyst, in the sense of his character, personality, moods, attitudes, and life experi-

ence, is always at work, for better or worse. It is my impression, incidentally, that substituting *subjectivity of the analyst* in these discussions for the more specific *character, personality, moods, attitudes,* etc., of the analyst can confuse because of the former expression's vague generality. More discriminating descriptions of what makes for subjective thinking are needed.

Both Reis and Druck assert that I have contradicted my own argument concerning Freud's replacement of the conversion theory with the signal anxiety theory. I included this discussion in my paper despite the fact that Freud (1926) refers only to new "discoveries"—which leaves ambiguous whether they were observational or conceptual discoveries—because I wanted to make a point not about Freud's genius, but about the theory that he had by then constructed. The title of my paper refers to psychoanalytic theory. In fact, Druck quotes the sentence in my paper that makes that clear. The argument is not about Freud's use of deductive reasoning, but about the inferential deductive richness of the psychoanalytic theory that Freud constructed—a composite theory that is sufficiently rich, reality bound, and inferentially interrelated that theoretical reasoning by Freud or by any other adequately knowledgeable person could identify theoretical explanatory problems when they occur, which is a sign of a mature theory.

Reis puts to the realist a dilemma: either the realist must assert that there is no subject, or he must admit that the dichotomy between critical-realist and subjectivist positions is actually a far more complex relation than one of opposing epistemologies. It would be quixotic to eliminate subjects (conscious persons) in order to, allegedly, do away with the idea of subjectivity altogether. Psychological subjectivity is natural to the human mind. The distinction between what is owing to the person (the subject) and what is owing to the object is in things and events themselves, and we require a verbal means of identifying the difference when it occurs.

The second alternative is also untenable. Complexity cannot reduce the dichotomy between what is subjective and what is objective in our experience of self and objects. As Cavell (1998) points out, psychological subjectivity must "normally include an ability to differentiate between subject and object in order to identify within evolving experience and

to conceptualize the difference between how things seem and how they are" (p. 458).

The opposition between these epistemological positions is tautological, as is evident from their dictionary definitions. It is not something that can be altered by any amount of "complexity" without making recourse to merely verbal solutions. Obviously, both objective and subjective elements may be at work in experience. The question is can we meaningfully differentiate them?

Reis's conjecture about my understanding of the paradigm shift from animistic to scientific thinking is mistaken. Aristotle formulated the rules of syllogistic validity and an early form of inductive reasoning in the fourth century BC. The problem was that his cosmological thinking, while perfectly logical, nevertheless relied upon basic animistic ideas: matter as pure potentiality actualized by psychic, substantial essences (Platonic forms relocated in species), primarily by teleological causality in a Ptolemaic cosmos. It was the replacement of these ideas by philosophers and scientists with the realization that material things are organized chemical substances, subject to efficient physical causality in a Copernican universe, that was at the heart of the Renaissance and Enlightenment paradigm shift from animism to science. It was the telescopic observations of Galileo, Descartes's studies of the behavior of light passing through media, Harvey's anatomical work, etc.—substantive discoveries—that brought about this paradigm shift (Weinberg 1998).

Moreover, logical validity and truth are independent; the conclusion of a valid argument is only true if its premises are true. Psychotic cosmological thought, even while being tragically detached from reality, is remarkable for its logical coherence. Logic alone could not be the driver of paradigm shifts.

I can agree that the "conjectured" (a rather indoctrinating thought experiment?) "Kleinian training" and "successful practice," in which the idea of unconscious fantasy is utilized, does not prove the existence of unconscious fantasy at work in the patient's psychic life—nor does it permit any other conclusion, for that matter. Implied by the conjecture is the relativistic notion that the consistent application of any theory and its specific technical rules can result in therapeutic success. This statement implies a malleability of individual psychic reality that makes it unsuitable for realistic observation.

Is this lack of an organized psychic nature true only of patients, or does it apply equally to analysts, who also can have at best a slippery awareness of who they are, leaving them with only a makeshift ability to differentiate themselves from their patient's transferences without encasing themselves in an unquestionable theory? A philosopher cannot but sense, in this conjecture, a slide toward Sartrean *nothingness* (C. Hanly 1979; Sartre 1943), precariously arrested by recourse to coherent authoritarianism and bad faith.

I notice that Reis's conjectural conclusion concerning the dubious existence of unconscious fantasies is inconsistent with Druck's account of Arlow's subjectivism based on the pervasive influence of unconscious fantasies on perception, I might add. Druck asserts that new perspectives can enable the discovery of new facts. I agree. But Druck then cites self psychology as evidence. Here there is a problem. The perspective of self psychology that focuses our attention on narcissism has produced results that contradict classical drive theory.

In particular, self psychology finds that the Oedipus complex is caused by narcissistic failures in the parents' responses to the intrinsically innocent burgeoning of sexual and aggressive feelings of the phallic/clitoral stage. Freudian analysts find that incestuous wishes and ambivalence are caused by drive development and will occur without parental failures. These observations are inconsistent. It was just this inconsistency that Goldberg (1976) was addressing, as discussed earlier. The philosophical and logical problem is that if two propositions are in contradiction and one of them is true, the other must be false.

The movement from perspective to perspective in psychoanalysis is useful and necessary for the clinical exploration of different basic assumptions, but when this exploration results in contradictory results, it is not just a matter of plurality of compatible theories. A possible case of perspectival compatibilities is the Kleinian perspective on very early development based on Freud's death instinct theory, but this perspective precipitated a consequential incompatibility concerning the nature of aggression between death-instinct Freudians and Freudians who reject the death instinct theory. Confronted with these complexities in the evolution of psychoanalytic theory, one can sympathize with those who adopt pluralism as a way out, combined with subjectivist epistemologies

of theory-bound (or otherwise-bound) clinical observation. This is essentially the path suggested by Goldberg (1976).

If clinical observation and logical theorizing cannot resolve these problems, psychoanalysis will remain a disintegrated body of knowledge—a plurality of theories, some of which are compatible while others are incompatible. The academic enemies of psychoanalysis will happily take this situation to be the result of the fact that psychoanalysis was and remains, as Wittgenstein (1966) claimed, a method of persuasion to believe a mythology (C. Hanly 1971), or, as Grunbaum (1984) claimed, the expectable results of different analysts practicing a suggestive therapy and thus making different suggestions to patients.

Logic is an asset in the work of checking out alternative theories precisely because it is impersonal and can do its work independently of the bias of investments in theory. However, one can appreciate the value of abstract reasoning without derogating or disregarding the place of personality, attitude, and feelings in the search for knowledge of human nature in oneself and in others. Consider the valid Epicurean syllogisms beautifully cloaked in the passionate, seductive language of 16th- and 17th-century love poetry in Shakespeare's sonnets and in Andrew Marvell's "To His Coy Mistress" (Person 1986), with their *carpe diem* conclusions. While knowledge and theoretical thinking are essential to good clinical work (Britton 2004; Britton and Steiner 1994), mutative interpretations are poetic in their synthesis of insight and affect.

Neither Reis nor Druck appears to share my interest in the fact that one need not be able to state the rules of valid reasoning, nor be familiar with tests for validity, in order to reason validly. I find this to be an interesting fact of our intellectual life, and I offer a topographical account of it that enables us to understand, for example, how psychotic cosmological thinking can be amazingly coherent despite its delusional premises. My point here is that the poetic and the personal aspects of the analyst's interpretations need not be at odds with objectivity, despite the risk that they *may* be, to the extent to which the relevant aspects of the analyst's personality remain dynamically unconscious.

I have previously dealt more extensively with the issue of clinical factuality and the matter of personality, idea, and fact (C. Hanly 1995) in an effort to explore whether there is "a way between subjectivity and objectivity that is also a way forward" (p. 906). I have explored the way

in which an idea (question) that may at first be considered only subjective, and that may have a subjective source, can enable what is objective to be seen. I have continued this exploration with a coauthor in a later publication (C. Hanly and M. Hanly 2001): "Clearly, the analyst's personality and subjectivity exercise their influence on the patient and on the process" (p. 526).

By way of a philosophical and theoretical conclusion, I will make the following points. A difficulty of subjectivist epistemologies for psychoanalysis is that they imply concurrence with some of the most telling philosophical—although, I think, ultimately mistaken—attacks on psychoanalysis. However, philosophically and theoretically, I find subjectivist epistemologies to be intrinsically problematic, since in order to function as epistemologies, they require a universal statement of principle in the place of a particular, useful account of a heuristic difficulty. And such universal statements give rise to inconsistencies and contradictions. In summary form, I would argue (deductively) that any observation that proves the truth of a subjectivist epistemology falsifies it because it is claimed to be an objective truth about knowledge.

It is this logical flaw in subjectivist epistemological theories that is alluded to in the jokes made by philosophers about solipsism. At least some of the subjectivist arguments cease to have this problem when they are treated as heuristic insights. The cognitive risks of strongly invested unconscious fantasies are of great importance to the clinical analyst without their epistemological elevation to a decisive influence upon all observations. This is also why, from the times of Plato and Aristotle, philosophers have espoused realism, even when their ontologies are idealistic and when sense experience is disparaged, as in Plato.

Plato was the first philosopher, I might add, to construct an argument against relativistic perspectivism as first elaborated by Protagoras (Owens 1959). For whatever reason, Plato (5th century BC, Book X, 598), in a reply to Protagoras, was thinking of a bed and considered whether the bed, which appears to be different when seen from different angles, is actually different. Plato's answer to Protagoras was that the bed appears different but is the same.

I hope that readers will find this discussion of some interest and usefulness. I am grateful to the Editor of *The Psychoanalytic Quarterly* for the opportunity to reply to my critics.

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106 Elm Avenue
Toronto, Ontario
Canada M4W 1P2

e-mail: charlesmhanly@gmail.com

Volume LXXXIII, Number 4

PSYCHOANALYSIS NATURALIZED

BY JASON A. WHEELER VEGA

Philosophy, Psychoanalysis, and the A-Rational Mind.
By Linda A. W. Brakel.
Oxford, UK: Oxford University Press, 2009. 197 pp.

Keywords: Theory, philosophy, a-rational thinking, Millikan, primary and secondary processes, Kant, phantasy, wishes, desire, belief, rationality, association, Davidson.

What is a theory for? Popper (1959) suggested: "Theories are nets cast to catch what we call 'the world': to rationalize, to explain, and to master it. We endeavour to make the mesh ever finer and finer" (p. 59). Here Popper captures several purposes for theories: to predict and control, to show how one thing causes another, and to place something within a network of logical and semantic relations. These functions may be taken as complementary or as radical alternatives, depending on where one stands. One might also take him up on his charming metaphor and set out to tighten the weave, to patch holes that might let important phenomena slip through, or to plait a larger net. Another function of a theory might be to ground a practice.

In her rigorous and demanding first book, Linda A. W. Brakel offers a mixture of answers to this important question. She has several major aims: to show that psychoanalysis has a foundation of theoretical principles that make it a coherent philosophical, scientific, and clinical enterprise; to make respectable the primary processes of the mind—*a-rational* thinking, as she refers to it, rather than *irrational*—not as an impoverishment of rationality, but as the basis of thought; and for her

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Jason A. Wheeler Vega is on the faculty of the Institute for Psychoanalytic Education affiliated with New York University School of Medicine.

philosophical analyses to make psychoanalytic theory more rigorous and, at the same time and reciprocally, to invite the philosophy of mind and action to psychoanalytic data often eschewed.

Mostly rewritten from articles published over the past thirty years, this is a clearly themed and significant monograph. Brakel's penultimate chapter, "Compare and Contrast: Gardner, Lear, Cavell, and Brakel," is ambitious and, if somewhat cursory, is also justified: in placing herself in this distinguished company, she locates her project within a small and challenging genre. What Gardner and Lear and Cavell do with (among others) Plato, Aristotle, Sartre, Wittgenstein, and Davidson, Brakel does (chiefly) with Kant and Millikan, and in so doing she introduces a serious new orientation to key aspects of Freudian theory. In particular, Brakel's use of philosopher Millikan's ideas parallels Cavell's use of the work of Davidson, each of which stands at the center of their theorizing.

Since publishing this monograph, Brakel has continued to write at the intersection of philosophy and psychoanalysis in two subsequent and complementary books. In another essay collection, not so tightly themed or cohesive as this one (Brakel 2010), she explores various themes in philosophy of mind, epistemology, philosophy of action, and philosophy of science, and gives a psychoanalytic account of the placebo effect. Though not, as she notes there, a continuation of her original project in this book, she explores some related topics, including different conceptions of unconscious belief and knowledge, and the relationship between a-rational (primary process) thought and traditional philosophical problems about vagueness (such as the classical sorites paradox—i.e., a paradox arising from vague predicates).

In her most recent book (Brakel 2013), she tackles the conjunction of empirical and theoretical psychology more broadly, and tries to reinvigorate classic problems in the philosophy of mind, further aiming to reinforce the place of psychology as such—as the study of the mental, in relation to experimental and neuroscientific work on the brain that has recently been at the apparent cutting edge of the field. Though she mentions it only briefly in a footnote, Brakel also has an empirical research program in psychoanalysis, mainly focusing on the operation of the primary processes and supporting the spirit of her naturalistic approach to theoretical problems.

The first chapter of this volume, "The Foundational Structure of Psychoanalysis," is a prolegomenon to the rest of the book, in which Brakel argues that psychoanalysis rests upon a core set of five fundamental principles. These include three assumptions, one methodological principle, and a theoretical corollary. In brief, her principles are: (1) psychic continuity—the lawfulness of the mental; (2) psychic determinism—the mental is causal; (3) the dynamic unconscious; (4) free association; and (5) primary and secondary process are equally important forms of thought.

A significant terminological variant that Brakel introduces with her fifth principle is the use of the term *a-rational* in preference to *irrational*. Though the latter has an established place in psychological and philosophical literatures, Brakel argues that the word includes an implicit devaluation in comparison with *rationality*. The irrational is usually viewed as a minor domain of error against the virtues of the rational. A key thesis of Brakel's book is that a-rational primary process is lawful, adaptive, and, in some profound senses, primary—hence her preference for a more neutral-sounding term. This is an astute move, both philosophically—to mark a distinction with a change in terms—and psychoanalytically—to shift associations.

Brakel asserts that these five theoretical principles underlie psychoanalysis as a general scientific theory and apply to all schools of clinical analysis. She states: "If the different metapsychologies [of various schools] do not include the five basic fundaments of psychoanalytic general theory, they are not psychoanalytic theories, whether or not the clinical theories and techniques give the impression of psychoanalytic common ground" (p. 4).[1]

Brakel makes this statement in a long footnote, but might better have addressed the claim at length in its own section. It would have been interesting to see her engage in a controversial discussion, as it were, with the proponents of approaches that are in the contemporary range of psychoanalytic praxis: those clinicians who are doing something interesting that they call psychoanalysis, but that might challenge some of these principles.

[1] All quotations from Brakel are from the subject book, *Philosophy, Psychoanalysis, and the A-Rational Mind*.

This also raises a question for Brakel: in offering a philosophical analysis of metapsychology, is she placing herself outside these categories and providing something a-theoretical, or is she proposing a distinctly Freudian account among contemporary alternative schools? My sense is the latter: Brakel's commitments are to the central tenets of Freudian theory, and her main aim is to prove through careful argument that these are in fact essential, not something that may be taken or left as one likes.

Following two introductory chapters, the book divides into several main sections. The first contains three chapters that are revisions of the author's prior articles, likely to be of most interest to philosophers with particular interests; they tackle certain positions of Searle, Perruchet and Vintner, Kant, and Reichenbach. In this first section, Brakel builds her case for a view of the primary and secondary processes as independent and equally valuable forms of thought.

Chapter 5 is the single chapter of the second section; here Brakel makes her most original and provocative contributions, which I will discuss later in this essay. Chapters 6, 7, and 8 offer lucid and useful analyses of concepts that are primary to both psychoanalytic theorists and psychoanalytic clinicians, including the drives, phantasy (her spelling), and varieties of belief, wish, and desire. The book concludes with two chapters briefly summarizing and comparing her work with other positions.

Kant posited that all human knowledge must be based upon twelve categories of understanding. Brakel argues in her third chapter that Kant's categories apply only to the rational or secondary processes of the human mind. Prior even to these a priori categories of thought, Brakel asserts that there is a more basic category, *association*, which is central to primary process. She notes that, though Kant in fact also posited an association principle in thought, this was seen as applying only to abnormal experiences. Kant held that the accidental combinations resulting from such a principle could produce only private and idiosyncratic ideas, not objective knowledge.

In contrast, Brakel's account gives equal value to primary and secondary processes. She runs carefully through Kant's positions on association and then develops her own case. She argues that, as a develop-

mental fact, we all pass through a period in which we develop subjective representations of objects, a process that serves as a necessary contrastive ground for later, secondary process understanding in accordance with mature, objective modes of thinking. Subjective associations formed in this way, though they may seem wild and unruly, are nevertheless far from random.

The fourth chapter, "Why Primary Process Is Hard to Know," continues the theme developed in the previous one, of the development of secondary process mature thinking from an earlier ground of primary process associationist thought, through a tour of the standard Freudian model of the dreamwork. Brakel's goal is to show how the progression from the dream *as dreamed* to the dream *as recalled,* and then to the dream *as recounted to another person,* moves from a primary process to a secondary process structure. Her method in this chapter hews, in a sense, to the old principle that ontogeny recapitulates phylogeny: as the dream develops in the adult dreamer, so the mind itself develops in the person.

A problem for Brakel's account here is that, though her goal is to show a progress from primary to secondary, the formation of dreams illustrates something different, as she herself describes. The work done to the primary process-based dream elements of the latent dream by the dreamer, generating the manifest dream and finally the dream as reported, in fact moves from secondary process through primary process and back again. The initial coherence of the unacceptable wish is transformed through primary process operations into the disguised manifest dream, and at the same time is given a newly coherent secondary process form. The psychoanalysis of the dream does not return us to a primary process structure of thinking—this would be no use—but passes through it temporarily and in reverse to arrive at the earlier (unacceptable) secondary process thoughts.

I think the most useful, broadly psychological reminder in Brakel's argument is that the primary processes—association, linking one thing with another—are essential to generate something to know about in the first place. But Kant's reluctance to treat a-rational association as a primary category of thought should give us pause. Although Brakel's aim is to redignify the primary processes, Freud's basic project is a *rationalizing*

one, in the sense of giving reasons and making logical links. The difficulty with knowing the primary processes of the mind directly is due to the secondary process ground onto which they must be placed to make them knowable.

Brakel's most original and ambitious contribution, and the philosophical core of her book, is her fifth chapter. She states that we must be able to see "the primary processes as mental states with content" (p. 64). We may wonder, as psychoanalysts, who doubts this? To motivate her project, Brakel must invoke contemporary philosophical doubts.

An apparent problem with the current tradition of epistemological holism in philosophy, which Brakel refers to as *attributionism,* is that it defines mental states as meaningful only if they are rationally arranged; but primary process states lack crucial features of rationality, so they cannot be meaningful. For instance, because primary process states lack reality testing, they cannot aim at the truth and so cannot be in error. A primary process state cannot even be a false belief because it cannot sustain the distinction between truth and falsity (something may be simultaneously true and false in a dream or unconscious fantasy). Brakel argues that a different norm, other than those of rationality, must therefore be found to determine the meanings of primary process states, or else we would have to give up on considering them meaningful. That norm, introduced from the work of Millikan, is the proper function of a mental state.

Brakel's first example of the *proper function* method of analysis concerns somatic systems. The proper function of sweat glands operating under *Normal conditions* is to reduce the temperature of the body by releasing sweat. This confers a selective advantage to the organism so equipped. *Proper function* is a carefully defined technical term developed by Millikan (1984), as is the word *Normal*, capitalized to indicate when she means it as a biological or medical norm, in contrast to something merely statistical. A Normal condition is that under which a naturally selected (adapted) device evolved. It is not just the average or typical condition for a device's operation. For example, most sperm never fertilize an egg, and could not do so in the face of contraception, but retain their proper functions nonetheless. As Millikan puts it: a "Normal explanation for proper performance of an adapted proper function is thus a general

explanation that tells how it happens that the device produces or does things that bear certain relations to its adaptation" (p. 44).

Brakel's second, more relevant example concerns beliefs. The perceptual systems of an organism are properly functioning if they produce true beliefs in an organism that contribute to its selective fitness. Brakel describes Millikan's example of perceptual representations in toads. Toads eat bugs but will also eat lead pellets that *we* might say look like bugs. Their perceptual systems are properly functioning under Normal conditions when the small black things within reach of their tongues are bugs, but are functioning under *abnormal* conditions when experimenters have proffered them lead pellets.

Nevertheless, in each case, Millikan argues, the toads have representations *of bugs*. These representations are *determinately* of bugs, and not of an indeterminate range of representable things, due to the fact that when functioning under Normal conditions they improve the animal's fitness. Bugs are the only things like that that toads' perceptual systems could have become adapted to represent. These representations are not beliefs and are not governed by rational structures. They function under a different norm: that of making a contribution to selective fitness.

Millikan's criterion in humans for a perceptual mechanism operating with its proper function under Normal conditions is that it produces true beliefs just often enough to benefit the selective fitness of the person. This may be a lot less than most of the time, contrary to intuitions or theories we might have about how often we must be correct in our beliefs, with the proper function of spermatozoa in mind.

From here, with the basic concepts of proper function and Normal and abnormal conditions in hand, Brakel goes on to propose and discuss the functions of two important classes of primary process mental states in humans: *phantasy* and *wish*. These are introduced in chapter 5, and then given a chapter each (7 and 8) for a fuller discussion with examples and considered objections. They are presented as primary process analogues of the core secondary process, propositional attitudes of *belief* and *desire*, respectively: phantasy is a cognitive attitude developmentally reached prior to belief, and wish a conative—motivational—attitude preceding desire. Brakel's conceptual analyses of these states here and in chapters 7 and 8 are the highlights of the book, for this reader.

Brakel begins by distinguishing a number of propositional attitudes,[2] drawing on the work of the philosopher Velleman, which are similar to belief in that they aim to represent some state of the world but do not share belief's intrinsic relation to truth—that of aiming to be true. A mental state that represents the world without aiming to be true must be something else, such as *supposing*, *hypothesizing*, *imagining*, or *phantasizing*.

Brakel focuses initially on *phantasizing*, an attitude toward states of affairs in which considerations of truth and falsity play no integral part. She holds this to be a developmentally earlier stage in the emergence of the core propositional attitudes in humans, before belief and desire, but a way of thinking that remains present in the mature thinker as part of the primary processes of the mind: active, for example, in dreams, psychotic states, and creative regression.

Using Millikan's model, Brakel explains that, whereas the proper function of the perceptual systems under Normal conditions is to produce true beliefs just often enough to increase reproductive fitness, the proper function of the mental mechanism of phantasizing is to produce phantasies. These phantasy states have the general features of primary process: they are timeless, operate on the pleasure principle, tolerate contradiction, and permit discontinuous agency. Nevertheless, phantasies have a determinate propositional content that is fixed by their proper function under Normal conditions. The specific Normal conditions for phantasy are threefold: (1) p is not presently the case; (2) p will be the case soon; and (3) having the phantasy p when it is not the case is useful practice for when it is.

To use a familiar example, the baby hallucinates the breast when mother is absent; mother will return; and having imagined the breast in the interim will allow the infant to latch on again, perhaps by having reinforced a memory of sucking or by keeping calm, or some such proximate end that keeps the infant going in the longer term.

Of course, this does not cover all phantasies; many are of states of the world that will not and cannot ever obtain. As Brakel notes, young

[2] A propositional attitude has the function of relating a person to a proposition. For example, Brakel *believes* that the mental is causal. The propositional attitude *believes* shows here what relation holds between Brakel and the idea at hand.

children are very good at phantasizing impossible things in play, such as being a dinosaur or a train—or even a dinosaur-train. Such phantasies are therefore classified as obtaining under *abnormal* conditions, not contributing to selective fitness. Phantasies performing their proper function under Normal conditions are those that connect closely with reproduction and survival, as in the many kinds of practice-play behavior observed in various species: play fighting with rivals, play mating with coevals, play stalking, and so on.

After introducing this idea in chapter 5, Brakel devotes chapter 7 to a fuller and more clinically applied exposition of her ideas about phantasy. There she also introduces a term of art, "neurotic-belief" (p. 106). These propositional attitudes differ from "beliefs-proper" in that they contain unconscious contents organized by primary process rules and are indifferent to evidence from secondary processes. Further, they may be supported by primary process-based "evidence," giving them a veneer of rationality. Therefore, once fixed, they are highly resistant to change.

Neurotic-beliefs become pathological when they are treated as secondary process states by their possessors. Striving naturally to apply our secondary processes, particularly for the purposes of planning and carrying out effective actions, we may use neurotic-beliefs as if they were conventional, true beliefs. An obsessional man, for example, thinking of himself neurotically as a second-class person, constantly finds "evidence" for that idea, and acts based on the continually "supported" notion that he is second-class. Even though he can agree that there is plenty of contradictory evidence for success in his life, and even that the very categories of second class and first class are specious when applied to people, he continues to feel and act as if it were true. On Brakel's model, this is because he has developed neurotic-beliefs about himself based on psychic reality-based "evidence" that cannot be disconfirmed.

Brakel notes that the clinical limitations of purely cognitive therapies make sense in this light: they are the wrong tools for the job, applying secondary process rules to mental states that are formed and maintained by primary process mechanisms. Cognitive therapy may help people with the pathological consequences of false-beliefs, which were formed on rational grounds and are solvent under secondary process scrutiny. However, a person who treats his unconscious phantasies and subsequent

neurotic-beliefs as true beliefs will continue to act on them on the basis of the psychic reality-based "evidence" gathered for them, which is mistaken for evidence gathered according to the reality principle.

An important question that arises about Brakel's approach here, despite its evident strengths, is whether the obsessional man with neurotic-beliefs, in my earlier example, is operating in an *a-rational* or an *irrational* mode, and whether Brakel's focus on the a-rational underappreciates the truly irrational in the mind, and hence also the background of rationality that conditions them both. Davidson (2004) observes: "The irrational is not merely the non-rational, which lies outside the ambit of the rational; irrationality is a failure within the house of reason" (p. 169). Cases in which people violate their own rational principles are cases of irrationality as such.

In contrast, in writing about the many associations made in the mind, Davidson observes:

> Simple cases of association do not count as irrational. If I manage to remember a name by humming a certain tune, there is a mental cause of something for which it is not a reason; and similarly for a host of other cases. [p. 186]

What Davidson means by "simple cases" should be made clear, and turns on the distinction between *reasons* and *causes*. Something may cause a mental state but not at the same time provide a reason for it—meaning that it is not able to play a role in justifying it. A reason for another mental state or an action, on the other hand, and on Davidson's view, may do both. The tune hummed does not have a rational connection to the name, just as any two things associated through classical conditioning need have no rational relationship to each other.

With one of her five core principles, *psychic determinism*, Brakel clearly indicates that she holds primary process mental states to be causal of others. Her position also entails, though less evidently, that they may be reasons for other states. Brakel argues over four chapters (5–8) that *phantasy*, *wish*, and *drive* are part of a group of primary process propositional attitudes. A propositional attitude may, if anything, be a reason for another mental state or for an action—unlike in Davidson's simple (purely causal) example of humming. For Brakel, their role as reasons

would have to be based on their propositional content fixed by their adaptive proper functions—for that is the norm she gives to determine what they mean—and not fixed by their logical and semantic relations to other propositional attitudes, as on the meaning holist view. But if something may be reason for a thought or action, it is surely thereby part of a rational system.

In the case of the man with neurotic beliefs described earlier, we might say that he is irrational—rather than simply a-rational—because he is failing to follow the *requirement of total evidence* (Davidson 2004): he is failing to believe what he thinks he should believe, given all he has to go on. This is not simply nonrationality; this is internal inconsistency: the agent recognizes the logical point of view but finds himself, against his own rules, continuing to hold ideas that are contrary to the balance of all he knows. He is not standing outside the house of reason; he is inside, vandalizing it.

Brakel elsewhere (2010) acknowledges that neurotic-beliefs may be irrational, in this sense, though a-rationally formed. However, though neurotic-beliefs may begin as a-rational phantasy states, they cannot remain solely that for very long—not longer than it takes to fix their propositional content, which brings them into the domain of reasons.

In addition to describing *phantasy* as a primary process parallel to belief, Brakel describes *wishing* in a particular technical sense—in contrast to the other core rational propositional attitude, desire. Again, Brakel fills out her discussion of wishing in its own chapter (chapter 8). She observes that *desire* and *wish* are often used interchangeably in everyday language, and that thinkers such as Freud and Davidson have made no major distinctions between them. She is critical of this oversight and suggests, for example, that "Freud's failure to differentiate wish from desire contributed to a lack of conceptual concision in aspects of psychoanalytic clinical theory" (p. 139).

If we again apply a proper function analysis, a *desire* under Normal conditions will aim to bring about the fulfillment of what is desired. In particular, in Brakel's description, a properly functioning desire leads the organism to take real steps toward bringing about the desired state of the world. In her terms, its constitutive function is a "readiness-to-act" (p. 144), much as the constitutive function of belief is to represent the

truth. In contrast, for Brakel, *wishing* is a primary process propositional attitude that, like *phantasy*, lacks the relation to the world that secondary process attitudes such as *belief* and *desire* intrinsically maintain.

The proper function of a wish under Normal conditions is to produce not a change in the world, but a phantasy that satisfies the wished-for state of affairs. The baby who has a desire for the breast will seek the breast; the baby with a wish will only dream it. As with her concept of phantasy, Brakel asserts that wishes that might serve some adaptive end in the future are properly functioning. So the dream of the breast is the outcome of a properly functioning wish under Normal conditions, whereas a wish to become a dinosaur-train is functioning under *abnormal* conditions (it cannot ever be the case). Brakel repeats her epistemological claim, following Millikan, that "it is these Normal conditions that will fix the content of these phantasies and wishes appropriately, in the absence of rationality" (p. 82).

There are some weak points in her definition, however, as she holds that any readiness-to-act may qualify such an attitude as a *desire*. In her example, gathering one's papers to write a book qualifies one for a genuine desire to write a book, even if the book is never written. Brakel resolves this by saying that a different attitude was held at a later time. So, for another example, consider the man who talks about sailing around the world, gathers books and plans on yacht building, collects sailing magazines and nautical charts, yet never learns to sail, does not build a boat, and in fact never even gets his feet wet. On Brakel's view, we should say that this man *desired* to sail around the world at time one, while collecting plans and papers (or even if he just thought of doing so), but later, at time two, he did not desire it—by then he merely *wished* to sail around the world.

To take another view, however, the initial acts in these examples seem already more like phantasizing than readiness-for-action. As with neurotic-belief given a veneer of rationality and mistaken for a true belief, there may be a manifest readiness-to-act, but in fact the actions may serve a different (pleasure principle) function for the person—perhaps escape from a dreary reality. It may be better to say, with hindsight, that the notional book writer and yachtsman never had real desires, but instead had wishes disguised as desires by manifest actions.

Brakel prefers to say that the mental state in this case is perhaps vague, or some combination of desire and wish, as one might say of the attitudes of very young children whose mental processes are still in formation; but saying this, while perhaps developmentally correct, gives up the tight differentia between these attitudes that makes Brakel's conceptual analysis otherwise so appealing. Despite the generativity of these notions, Brakel's adherence to Millikan's idea of evolutionary adaptation may lead to a narrow conception—ironically biased toward the reality principle—of what is adaptive for the organism, since her inclusion of *play-fighting* but exclusion of *dinosaur-train-playing* suggests little interest in the possible adaptive functions of pure pleasure principle-based phantasy.

To move back slightly within the book, Brakel also gives a valuable conceptualization of the drives in chapter 6. One evident problem with understanding the drives is the variability of their objects, such that so many may satisfy a drive that one cannot say that it has a singular determinate content. Brakel gives an example from infancy:

> For Baby X the objects of these oral drives are X's mother's left breast and nipple and her right breast and nipple, and a bottle and nipple, and X's father's face as he holds X and the bottle, and the milk, and mother's face, and how it feels being held and fed, and how these faces and breasts (and bottles) look, and the pacifier and the hand of its provider, and the blanket edge, especially how it feels in X's mouth—any part of this and all of it together. [p. 89]

Brakel states that, rather than having a singular determinate object, what might satisfy a *drive*, as opposed to a more clearly specified attitude like a *desire*, is a *set of objects,* which may be linked quite idiosyncratically (through association, not rational relations—recall again the humming linked with a name). This does not make them completely indeterminate, but instead they may be considered determinate according to categories that have developed through primary process mechanisms. For Baby X, the set of objects satisfying oral drives is large and subjective, to be sure, but based upon something relevant—namely, X's experiences and subsequently developed network of associative links.

Once more applying Millikan's (1984) concept of proper function, Brakel outlines criteria for a proper function determination of the objects of drives. This is accomplished in two steps, specifying first the proper function of the objects and second the Normal conditions under which they must obtain to contribute to fitness. First: (a) drive objects must be organized into a set based on primary process associative mechanisms, not randomly; (b) the objects must satisfy the aims of the drive; and (c) the variability of the set, the flexibility in drive objects, itself must contribute to drive satisfaction. Second: Normal conditions must be specified, which for the drives are just those in which they may be satisfied by multiple objects.

Although the author asserts that these revised concepts of drive, belief, phantasy, neurotic-belief, desire, and wish are derived from, and therefore depend upon, her analyses developed in chapter 5, I think that in fact they stand up independently of Brakel's philosophical objections to epistemological holism and her adherence to every part of the proper function methodology taken from Millikan. This means that even readers (such as this reviewer) who think that there are problems with parts of Brakel's core philosophical position can make immediate use of her fine conceptual analyses in their thinking and work. To the extent, though, that Brakel's arguments do indeed derive from Millikan's ideas, her foundational project for psychoanalysis will depend on how well those ideas hang together.

Millikan's boldly titled first book, *Language, Thought, and Other Biological Categories* (1984), is a tour de force in which she introduces the concept of *proper function* and then applies the idea to major philosophical problems. Her approach is part of a fairly recent approach in epistemology known as naturalism. In his essay "Epistemology Naturalized," Quine (1969) predicted and encouraged the "rubbing out of boundaries" (p. 90) between philosophical epistemology and nearby disciplines, such as psychology, linguistics, and evolutionary theory. In this spirit, Millikan puts forward a compelling naturalist manifesto:

> If we can understand why singing fancy songs helps song birds, why emitting ultrasonic sounds helps bats, why having a seventeen-year cycle helps seventeen-year locusts, why having ceremo-

> nial fights helps mountain sheep, and why dancing figure eights helps bees, surely it is mere cowardice to refuse even to wonder why uttering, in particular, *subject-predicate sentences, subject to negation*, helps man. [1984, pp. 7-8, italics in original]

Millikan consequently develops an approach to core philosophical problems of mind and language that are based, she asserts, upon "a nonfoundationalist and nonholist epistemology" (p. 13), and she defines and specifies mental states by their naturally selected ends: "Only in virtue of one's evolutionary history do one's intentional mental states have proper functions, hence does one mean or intend at all, let alone mean anything determinate" (p. 93).

Brakel's major concern, following Millikan's lead, is that holist accounts of meaning pose "a serious objection to the primary processes as conceptualized by Freud" (p. 70). As discussed earlier, primary process mental states like *phantasy* and *wish* lack some core features of rationality, and so holism seems to threaten to make these meaningless. She grants that "attributionism" has "some appeal" (p. 66) by showing how "the very concepts of a-rational, irrational, and inconsistent mental content states depend upon a background of rational mental states against which they can be contrasted" (p. 67). But still Brakel rejects the position as a model for determining meaning for the primary processes, preferring Millikan's proper function method. She chooses Davidson, not unreasonably, as representative of the holist tradition in contemporary philosophy of mind and language, though others whom she mentions might also have served.

Davidson's (2004) argument for holism, like Kant's work on the categories of understanding, is a transcendental one: he sets out the conditions for an organism to be rational—what must obtain for an agent to be an agent, a person a person—namely, a substantial degree of consistency and coherence:

> The meaning of a sentence, the content of a belief or desire, is not an item that can be attached to it in isolation from its fellows. We cannot intelligibly attribute the thought that a piece of ice is melting to someone who does not have many true beliefs about the nature of ice, its physical properties connected with

> water, cold, solidity, and so forth. The one attribution rests on the supposition of many more—endlessly more. [p. 183][3]

Davidson crisply notes: "Mental states and events are the states and events they are by their location in a logical space" (2004, p. 184). The concept of logical space is found in Wittgenstein and is put to work by Sellars in epistemology:

> In characterizing an episode or state as that of *knowing*, we are not giving an empirical description of that episode or state; we are placing it in the logical space of reasons, of justifying and being able to justify what one says. [1963, p. 169]

On this holist view, what would give primary process states their content—and what makes them fitted to being reasons for acting—is just what gives the rest of the agent's states their content, which is the agent being able to participate in the domain of reasons, in the logical space "of justifying and being able to justify what one says."

Consider, for example, how one interprets a dream by standard technique. One does not simply accept the content of the manifest dream (generated by primary process from unacceptable secondary process wishes), or generally interpret directly from it (though one may do so, using one's own associations, one's own space of reasons), but one usually asks for the patient's associations, placing the primary process-created, manifest content of the dream into the larger context of *all* the agent's intentional states, into a context—a logical space—that makes the agent someone whose dreams we can consider a phenomenon to be interpreted.

Brakel's main objection to holism is that it is chauvinistic toward the primary processes and to creatures we might see as subject to them. On a holist view: "Children under the age of around three years, primates, adults in dream-states, and certainly mammals in other orders, and so on, will lack mental content states" (p. 67). Rorty (1979) calls this kind of worry the "unfair to babies" (p. 181) objection. Though it sounds

[3] Wittgenstein (1969) expresses this with his usual epigrammatic flair and also a developmental sensibility: "When we first begin to *believe* anything, what we believe is not a single proposition, it is a whole system of propositions (Light dawns gradually over the whole)" (p. 21, English version).

unfair (there is some pathos in the objection), we might just bite these bullets. We might say that the infant, to take the hardest case, has mental states that are not yet determinately about something, or may be about some combination of a real thing and a fantasy thing (the transitional object), and will not be reliably meaningful until some later time. Millikan (1984), in fact, says this, and Brakel (pp. 148, 154) also suggests some vagueness in young children's mental states, as discussed earlier.

Rorty (1979) argues:

> We may balk at the claim that knowledge, awareness, concepts, language, inference, justification, and the logical space of reasons all descend on the shoulders of the bright child somewhere around the age of four, without having existed in even the most primitive form hitherto. But we do not balk at the thought that a cluster of rights and responsibilities will descend on him on his eighteenth birthday, without having been present in even the most primitive form hitherto . . . . But in both cases what has happened is a shift in a person's relations with others, not a shift inside a person which now *suits* him to enter such new relationships. [p. 187, italics in original]

Granted that there are, perhaps, as Brakel argues, some "primitive forms," this holist view proposes an essential shift in perspective and scale: from the proper functioning of systems or mechanisms or devices within an organism, to the relations between that organism and others within a logical space in which it can be determined what each thinks and wants and means.

In her refinement and discussion of several types of proper function, Millikan comments on the proper functions of devices that are intrinsically relational. For example, an amoeba is motile *in relation to* chemical gradients beneficial or harmful to it. In this case, Millikan (1984) observes, "the whole amoeba seems to be the relevant 'device'" (p. 39). Talk of *devices*, including parts of the body, the primary and secondary processes of the mind, the system unconscious, drives, propositional attitudes such as belief, desire, wish, and phantasy, is one level of analysis; another is the level of the *person*. This is a distinction that cannot be rubbed out, even for such a good cause as naturalism.

Recall that Millikan intended to develop "a nonfoundationalist and nonholist epistemology" (1984, p. 13). These concepts are linked, and Brakel's approach in this book also engages some problems of foundationalism, in two different ways: one through her borrowing of Millikan's method, and the other through her overall goal of providing a philosophical foundation for psychoanalysis.

Millikan says of her naturalistic approach to epistemology, the proper function method of analysis:

> We can climb on the shoulders of our realism. It supports us not by *grounding* our knowledge and certainly not by grounding it in some prior order—some order other than the natural order. It supports it by explaining what our knowledge is and what it is not and, schematically, how we came to have it. That such an explanation can be given does not *ground* anything. But certainly it should make us feel more comfortable. Put it negatively. If we could give no explanation at all for what our knowledge is or of how we come to have it, surely we would have reason to contemplate being skeptics. [1984, p. 332, italics in original]

The first specific problem here concerns whether, in spite of her intentions, Millikan's method does in fact include a foundationalist element. Millikan tries to steer carefully among the hazards of modern epistemology, knowing where the rocks are, mapped by Sellars (1963)—one of her teachers—and others.

The best-known critique of foundationalism in epistemology is by Rorty (1979). Epistemology is in error if taken as a project of grounding the knowledge claims of all parts of culture in an understanding of how the mind works—in particular, in an understanding of how the mind represents the external world. This is a very specific critique. A somewhat broader notion from the work of Sellars that Rorty draws upon is the idea of trying to ground the *epistemic*, things we can claim to know, in the *non-epistemic*, in things outside the logical space of reasons—in "some prior order," to borrow Millikan's phrase (1984, p. 332). Though Millikan prefers to make a distinction between kinds of prior order, the non-epistemic includes purely causal things in the natural order, such as the functioning of systems in the brain, or the associations of classical

conditioning. This is where holism and foundationalism in epistemology intersect, on the holist assumption that only mental states that can be reasons can support or undermine knowledge claims, these being the objects of theories of knowledge.

Millikan is equivocal about where her method aims. On the one hand, Millikan's proper function account is given as an *epistemological* method, as a way of determinately fixing the content of intentional mental states. In other words, saying what something means based not, as on holist accounts, on what other things mean, but on the proper functioning of "devices"—parts or systems of the organism.

But, as Rorty (1979) puts it:

> A claim to knowledge is a claim to have justified belief, and . . . it is rarely the case that we appeal to the proper functioning of our organism as a *justification*. Granted that we sometimes justify a belief by saying, for example, "I have good eyes." [p. 141, italics in original]

We may note that a perceptual system is working correctly, but does this tell us more than that the organism has the equipment necessary for forming representational states of the right kind? Can it also serve to tell us how well an organism's epistemic states may fare in relation with others of its own or another's? Or again, how can something that does not mean anything justify something that does mean something? This is usually where norms of rational relations apply as transcendental conditions for knowing something (propositional) as such.

On the other hand, Millikan writes that her goal is to explain "how we come to have" knowledge about the world, which is a *scientific* but not necessarily an epistemological goal. Rorty (1979) discusses the cognitive turn in psychology as

> . . . the development of explanations of behavior in terms of inner representations without, necessarily, any linkup with the justification of beliefs and actions . . . . Once explanation and justification are held apart there is no reason to object to explanation of the acquisition of knowledge in terms of representations. [p. 210]

If Millikan's theory of proper functions is a cognitive or scientific one, concerned only with explanation—of showing how language and thought might come to benefit the organism that generates them—then it avoids this difficulty and provides something elegant and widely usable.

To come to the second, more general aspect of foundationalism that arises within Brakel's project, one may notice that Rorty's technical critique of modern epistemology is also interwoven with some "psychoanalytic" observations. He suggests that "the desire for a theory of knowledge is a desire for constraint—a desire to find 'foundations' to which one might cling, frameworks beyond which one must not stray, objects which impose themselves, representations which cannot be gainsaid" (1979, p. 315).

Millikan writes (as quoted earlier) of what it could mean to have an "explanation" for human knowledge: "Certainly it should make us feel more comfortable," for otherwise "surely we would have reason to contemplate being skeptics" (p. 332). However, as Rorty suggests, "Only the professional philosopher has dreamed that . . . [justification] might be something else [than holistic and social], for only he is frightened by the epistemological skeptic" (p. 181). The specter of skepticism—that we do not know anything at all, that everything is a dream or a trick, and so on—is not really a live problem, and certainly not for naturalists. More likely, it is a "theoretical" problem invoked as a justification for something that we want to do, such as to develop a new philosophical system.

Brakel's overall goal of providing a philosophical foundation (the theory of proper functions) for an enduring part of psychoanalytic theory (the existence and role of the primary processes of the mind) does seem to me to encounter this latter motivation and consequently this critique. Many analysts will be puzzled about why elements of metapsychology would be thought to need grounding or foundations from (even naturalist) philosophy. This will be an issue not only for those analysts who do not even see themselves as natural scientists but rather, broadly speaking, as applied hermeneuticists, but also for analysts who think that psychoanalytic theory stands up quite well on its own, without something external to justify it and, further, those who think that the

very goal of providing a philosophical foundation for psychoanalysis is perhaps a kind of anxiety.

Alongside this admittedly psychologizing critique, one might consider another proposal of Sellars's, which applies to any project like Brakel's: "For empirical knowledge, like its sophisticated extension, science, is rational, not because it has a *foundation* but because it is a self-correcting enterprise which can put any claim in jeopardy, though not *all* at once" (1963, p. 170, italics in original). From this point of view, the security of psychoanalysis would lie not in having a firm philosophical foundation, but in the spirit of curiosity found in any progressive discipline and in the gradual effort to "make the mesh ever finer and finer" (Popper 1959, p. 59).

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156 Fifth Avenue
Suite 1200
New York, NY 10010-7742

e-mail: jasonwheelerphd@gmail.com

Volume LXXXIII, Number 4

BOOK REVIEWS

A PSYCHOTHERAPY FOR THE PEOPLE: TOWARD A PROGRESSIVE PSYCHOANALYSIS. By Lewis Aron and Karen Starr. New York/London: Routledge, 2013. 464 pp.

A book that aspires to create a vision for psychoanalysis to rise above its insular and elitist tendencies is intriguing. Indeed, it is courageous at the present time to conjure a bright future for psychoanalysis based on a critical reading of its own history and on the fantasy, which can be traced back to Freud, of realizing "a psychotherapy for the people." Lew Aron and Karen Starr are well qualified to guide us in this effort, as he is the author of seminal works on relational psychoanalysis, edits the series on relational psychoanalysis for Routledge (of which this book is part), and is the Director of New York University Postdoctoral Program in Psychotherapy and Psychoanalysis—one of the few thriving psychoanalytic institutes—while she is the author of a book on psychoanalysis and Judaism, as well as a candidate at the same institution.

Aron and Starr deliver in terms of introducing us to a kind of counter-history of psychoanalysis, paying attention to a variety of neglected and little-known figures and topics—for example, Rabbi Joshua Liebman, who wrote a best-selling book advocating the integration of psychoanalysis and religion.[1] Yet *A Psychotherapy for the People* is more of a polemical than a scholarly book, borrowing heavily from secondary sources, especially from cultural studies. It has the virtue of never shrinking (pun intended) from passionately defending a consistent set of beliefs.

The main argument of the book is that the binary opposition between psychotherapy and psychoanalysis has had a kind of haunting and limiting effect on much of the history of psychoanalysis, reverberating in a multitude of other, problematic binary oppositions having to do with gender, sexual orientation, and religion. Suggestibility is the underlying

[1] Liebman, J. L. (1946). *Peace of Mind.* New York: Simon & Schuster.

characteristic of psychotherapy, a mark of its inferiority in comparison to psychoanalysis, which allegedly depends upon the more challenging goal of analyzing the transference.

It is surprising that the authors make the distinction between psychoanalysis and psychotherapy so central, as this issue no longer arouses the vehemence that it did in the past. The number of psychoanalysts who are invested in this distinction has dwindled and, in my estimation, is growing smaller every day. Furthermore, while I would agree that the distinction has been wielded to establish the superiority of psychoanalysis, the authors are elusive about where they ultimately stand. Would they accept the value of differentiating kinds of psychoanalytic therapies dimensionally—adding a broad spectrum of gray to the former black-and-white distinction? Or do they think we ought to abandon the distinction as unnecessary and harmful?

The authors support Wallerstein's notion of seeking a common ground across psychoanalytic perspectives,[2] stressing that they wish to include both psychoanalysis and psychotherapy. They also introduce the notion of *dialectical thinking* as a way to overcome binary oppositions, but they do not linger over it or try to explicate what this term means to them.

A Psychotherapy for the People is a long book. The early chapters rehearse familiar aspects of the history of psychoanalysis in America and begin to formulate a tale that celebrates the contributions of relational thinkers such as Stephen Mitchell, Jessica Benjamin, Emmanuel Ghent, Irwin Hoffman, Adrienne Harris, Philip Bromberg, and Paul Wachtel. The authors acknowledge the influence on their thinking of both feminism and deconstruction. They document changes in modern medicine that initially created the opportunity for psychoanalysis to emerge as a treatment, not just a form of care.

The following three chapters—5, 6, and 7, respectively—cover "Psychoanalysis in Uniform," "Psychoanalysis as War Hero," and "Psychoanalysis as Holocaust Survivor." The authors make a compelling case for how the war produced the need to treat trauma, noting that psychoanalysis was perfectly poised to accept the challenge of helping patients achieve

[2] Wallerstein, R. S. (1990). Psychoanalysis: the common ground. *Int. J. Psychoanal.*, 71:3-20.

recovery. During this era, psychoanalysis grew in stature, although analysts were becoming more conventional than in the past. It is a key feature of the authors' interpretation of Freud that he was "optimally marginal" (p. 91)—that is, positioned both inside and outside mainstream culture.

Aron and Starr are particularly critical of ego psychology, which promoted the ideal of adaptation and autonomy for patients, as well as orthodoxy in technique, wherein the analyst is regarded as "invulnerable, rational and masterful, while all vulnerability, irrationality, and dependency was attributed to the patient" (p. 125). In fact, the authors venture a psychological interpretation in this context: that the idealizing of independence and autonomy was "a manic defense against vulnerability and loss" (p. 125). Ego psychology downplayed the pervasive and unruly aspect of the unconscious, but given that its main exponents were refugees from totalitarian regimes, it is not so perplexing that they were inclined to cherish autonomy.

Aron and Starr are also critical of ego psychology for seeking to package psychoanalysis as an "advanced scientific treatment" (p. 129). They are suspicious of ego psychology for endorsing an objectivistic, positivist view of science, failing to appreciate this psychoanalytic development as the moment when it dawned on psychoanalysts that there was a price attached to remaining isolated from other sciences. Ego psychologists therefore began to undertake empirical research as a way both to connect with other fields and to examine psychoanalytic beliefs. A fresh assessment of the scientific aspirations of ego psychology is timely since it was the source of the current, growing movement in psychoanalysis that has embraced research; however, a full assessment would entail an extensive review of the original sources.

The shadow of the Holocaust falls on psychoanalysis in ways that were unrecognized for a long time. Aron and Starr strive to correct this, noting that Freud left Vienna in 1938, barely in time (four of his five sisters were killed at Auschwitz). They also point out that America was flooded with European analysts who had escaped with their lives.

It is helpful to appreciate the extent to which mourning Freud's death in 1939 became entangled with mourning the loss of European Jewry. Aron and Starr depict the environment in Vienna as vehemently

anti-Semitic, which Freud both tried to resist and capitulated to at the same time. They do not pay much attention to the cosmopolitan, multicultural sensibility of *fin de siècle* Vienna, however. They read Freud as experiencing vulnerability as a Jew, but also as defensively transforming that insecure status by finding a way to attribute it to all of humanity, and by internalizing the notion of Jewish men as castrated, feminine, and hysterical.

The question of what it meant for Freud to affirm being Jewish is not easy to fathom (a topic that takes up chapters 12–16). Aron and Starr see Freud as having disavowed the vulnerability he must have experienced, and also as a victim of Jewish self-hatred. Following others, the authors see Freud's last work, *Moses and Monotheism* (1939, *S. E.,* 23), as an implicit attempt to contend with his Jewish identity.

It is an open question in my mind whether Freud had a measure of self-acceptance and self-love, rather than having internalized the anti-Semitism of his time—as is claimed by Aron and Starr, following Boyarin.[3] Personally, I have always found it strangely moving and affirmative that Freud chose to state, in "An Autobiographical Study," that he was born a Jew and had remained one (1925, *S. E.,* 20; also quoted by Aron and Starr, p. 235).

Aron and Starr react to Freud's intense interest in Ancient Greek culture as if it were a substitute for the Hebrew Bible. They convey disappointment that his Jewishness did not lead back to Judaism. They do not consider the possibility that, while Freud loved being Jewish, he also loved other things, refusing to regard his other interests as threatening or inconsistent with a strong Jewish identity. Like Maimonides, Freud wished to defend an erudite, integrated Jewish identity.

Still, Aron and Starr are on target in depicting Freud as having a German Jewish complex, adulating Western culture, and distancing himself from his Hasidic family origins. The authors are also quite justified in complaining about Freud's cynicism about religion and spirituality. His inclination to think of psychoanalysis as superior to religion and spirituality is an excellent example of the sort of binary that contributed to psychoanalysis being perceived as arrogant.

[3] Boyarin, J. (1997). *Unheroic Conduct: The Rise of Heterosexuality and the Invention of the Jewish Man.* Berkeley, CA: Univ. of Calif. Press.

A satisfying aspect of this book is its playfulness. Chapter 9, "Comic Book Crusaders: Psychoanalysis as Superego," takes up the appropriation of psychoanalysis in popular culture—for example, the mass-market comic book *Psychoanalysis,* published by Entertaining Comics (of *MAD* magazine fame), which depicts the psychoanalyst as superego. In this context, they introduce the best-selling book by Rabbi Liebman, mentioned earlier, which argues that "Judaism was optimistic and life-affirming; human beings are created in God's image and have the potential for good. Our biological drives are not inherently destructive or sinful but can be channeled, sublimated, sweetened, toward the good life" (p. 176).

Aron and Starr highlight Liebman's interest in mutuality, which emerges from the influence of thinkers such as Buber and Rosenzweig, and anticipates relational psychoanalysis. In learning about Liebman, I was curious enough to read *Peace of Mind*,[4] and what impressed me most was the author's prescient argument affirming the value of emotionality and discerning emotions as the basis of the link between psychoanalysis and Judaism. Liebman offers a surprisingly bold effort to think through the divide between secular culture and religion.

Chapter 10 of *A Psychotherapy for the People* explores the well-trodden territory of Charcot's influence on Freud and the less-well-known influence of Bernheim, whom Freud visited in Nancy in 1889. Aron and Starr follow Makari's account[5] of Bernheim's epistemological skepticism, as well as his move away from hypnotism to psychotherapy. This leads to chapter 11, which dramatically takes up the question of whether Freud practiced genital stimulation with his women patients, a widely accepted practice at the time. Aron and Starr revel in their cultural-studies logic of how clitoral stimulation can be construed as "playing with the Jew" (p. 216). While the authors are provocative on this point, it is a little disappointing to find that no substantiating evidence is provided; nor do the authors grapple with the fact that such bodily treatment was inconsistent with Freud's evolving commitment to disorders of the mind.

The last chapter of the book, "Monsters, Ghosts, and Undecidables," offers a terrific discussion of psychoanalysis as a cultural norm versus a

[4] See footnote 1.

[5] Makari, G. (2008). *Revolution in Mind.* New York: Harper Collins.

countercultural phenomenon by comparing the theories of San Francisco analysts Thomas Ogden and Owen Renik. Aron and Starr's stated aim is to transcend the apparent differences between these two theorists. Ogden sees the goal of psychoanalysis as helping patients to be alive—in his language, to dream themselves into existence. He advocates "wasting time," an explicit rejection of therapy as aiming to lessen symptoms and increase greater productivity. Thus, the force of Ogden's view is countercultural, seeing psychoanalysis as removed from the values of the dominant culture.

It is in the name of the patient's freedom that Ogden is wary of the analyst imposing his/her beliefs on the patient, rather than intentionally conveying a political message. In a different vein, Renik is a critic of the extent to which psychoanalysis has been "an unpractical and unscientific, self-promoting cult" (p. 387); he is particularly skeptical of open-ended psychoanalyses that persist without goals, coming down on the side of accomplishing changes in the real world.

Aron and Starr set up a contrast between Ogden and Renik in order to think through their differences. They defend a "both/and" perspective, showing the advantages of each, and rotating and viewing each of them from new angles. This culminates with the authors' celebration of vulnerability, derived from Levinas as well as from relational psychoanalysts Benjamin and Bromberg. The vulnerable analyst, capable of appreciating mutual vulnerability in his/her relationship with patients, is the appealing antidote to the posturing, omniscient analyst, whom Aron and Starr characterize as "phallic, abstract, rational, autonomous, disembodied, a blank screen, a surgeon" (p. 397).

At this point, it is evident that the authors are invested in continuing to wage old battles. While the debate between the two ideologies here typified as Ogden and Renik raises valuable questions, its connection to the theme of "a psychotherapy for the people" is tenuous.

In the beginning of the book, Aron and Starr lay out a vision of psychoanalysis as it was supposed to be: "open, free, innovative, humanistic, social activist, and more progressive spirit" (p. 17). This is a vision that deserves to be fleshed out further—with attention to actual efforts to realize it, for example, such as the Lafarque Clinic in Harlem. This clinic was created by Frederic Wertham and Richard Wright (yes, that Richard

Wright) in order to bring psychoanalytic psychotherapy to a working-class population, from 1946–1958.[6] In addition, a doctoral program at the City University of New York (with which I am associated) has run a mental health clinic in Harlem from the 1960s to the present, offering psychoanalytic therapy to a predominantly ethnic minority patient population.

Aron and Starr owe us more of an account of how they imagine psychoanalysis should move forward. They are blithely optimistic about the future but vague on details, beyond hoping that relational psychoanalysis will continue its ascent.[7] The really hard problem—that psychoanalysis is perceived as less relevant in our culture—demands attention, as does an honest reckoning with those cultural trends that explain its diminished status. Nevertheless, this is a book that I heartily recommend for its presentation of the stimulating discussions and debates that are necessary for the survival of psychoanalysis.

ELLIOT L. JURIST (NEW YORK)

INTERVIEW AND INDICATORS IN PSYCHOANALYSIS AND PSYCHOTHERAPY. By Antonio Perez-Sanchez. London: Karnac, 2012. 262 pp.

Many psychoanalysts consider their science and their clinical method to be in a state of crisis. They regret the lack of people with emotional problems who are choosing psychoanalysis as their preferred treatment approach and the decreased number of colleagues who want to develop professionally by choosing psychoanalytic training to enrich themselves emotionally and intellectually. With regard to the first group, the patients, the seriousness of pathology is often considered to be an additional problem. With regard to the latter group, the analytic trainees, their advancing age is also viewed as a negative development. Considered this way, the image of psychoanalysis seems to some to be drying

[6] This clinic is discussed in: Zaretsky, E. (in press). *The Political Freud.* New York: Columbia Univ. Press.

[7] Currently, relational psychoanalysis dominates Division 39, the section of the American Psychological Association dedicated to psychoanalysis, but has not yet achieved much international recognition.

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INTERVIEW AND INDICATORS IN PSYCHOANALYSIS AND PSYCHOTHERAPY. By Antonio Perez-Sanchez. London: Karnac, 2012. 262 pp.

Many psychoanalysts consider their science and their clinical method to be in a state of crisis. They regret the lack of people with emotional problems who are choosing psychoanalysis as their preferred treatment approach and the decreased number of colleagues who want to develop professionally by choosing psychoanalytic training to enrich themselves emotionally and intellectually. With regard to the first group, the patients, the seriousness of pathology is often considered to be an additional problem. With regard to the latter group, the analytic trainees, their advancing age is also viewed as a negative development. Considered this way, the image of psychoanalysis seems to some to be drying

[6] This clinic is discussed in: Zaretsky, E. (in press). *The Political Freud.* New York: Columbia Univ. Press.

[7] Currently, relational psychoanalysis dominates Division 39, the section of the American Psychological Association dedicated to psychoanalysis, but has not yet achieved much international recognition.

up and doomed to extinction: no new patients, no new analysts, end of story!

The explanations for this are often viewed as external: economic crises, cultural shifts, and the growth of alternative, mostly shorter and cheaper forms of treatment. Although the importance of these external factors cannot be denied, a small but growing number of authors point as well to the influence of the analyst: his or her inner, emotional, partly unconscious relationship to psychoanalysis—that is, his or her analytic identity. I have previously formulated this in terms of *psychoanalysis as an internal object.*[1]

This state of affairs has led to a renewed interest in the often-described but recently less popular subject of assessment of so-called *analyzability*. In the past, this was examined from the point of view of the luxury of a large supply of patients, but more recent contributions approach it from the point of view of scarcity and crisis. It would be interesting to look at the way this shift is manifested in the content of papers dealing with this subject, but that would fall outside the scope of this review.

The current climate necessitates our rethinking our theories about, and our procedures with respect to, initial interviews and the initiation of psychoanalytic treatment. This book by Perez-Sanchez comes at a good time both for practicing psychoanalysts and for those in training for the profession.

Perez-Sanchez is a psychiatrist and a Training and Supervising Analyst in the Spanish Psychoanalytical Society. He has worked for many years in psychiatric settings, and he is now a psychoanalyst and psychotherapist in private practice in Barcelona. He has published several articles and books in Spanish. Given the title of one of his previous books,[2] it is not surprising that one of the characteristics of the book under review is that Perez-Sanchez wanted to write for a wider audience than psychoanalysts alone. His hope is that, as mental health professionals

[1] Wille, R. S. G. (2008). Psychoanalytic identity: psychoanalysis as an internal object. *Psychoanal. Q.,* 77:1193-1229.

[2] Perez-Sanchez, A. (1996). *Prácticas Psicoterapéuticas: Psicoanálisis Aplicado a la Asistencia Pública* [*Psychotherapeutic Practices: Applied Psychoanalysis in Public Mental Health Care*]. Barcelona, Spain: Editorial Paidós.

gain more knowledge about psychoanalysis and psychoanalytic psychotherapy, the likelihood that they will refer patients who may benefit from these methods may increase (this exemplifies how the shift from wealth to scarcity of analytic patients affects psychoanalytic writing). Whether the book will have the intended effect is questionable, but it is a goal worth striving for.

To achieve the aim of conveying his message as widely as possible, Perez-Sanchez has structured the book quite cleverly. He deals initially with various themes on a rather basic level and then deepens his discussion. Moreover, he does not limit his topic to psychoanalysis but discusses the entire spectrum of the various forms of psychodynamic treatments, ranging from supportive therapy (one session per week) to psychoanalytic psychotherapy (two per week) to psychoanalysis (four or five per week). This has the advantage of making the text easily accessible to a wider audience than exclusively psychoanalysts and analytic candidates. The downside is that some parts of the book might seem too basic for the experienced analyst, although other parts may have a lot to offer them as well. After all, not all analysts are equally experienced and proficient in the initiation of psychoanalytic treatment.

The book's first chapter contains a statement about its theoretical orientation, which is along the Freud-Klein-Bion axis. Since this orientation includes a broad range of psychoanalytic theories, and since the author does not address these theories dogmatically, the book is pleasant to read; it feels like a stroll through contemporary psychoanalysis.

Perez-Sanchez describes a wide range of therapeutic goals, extending from symptom relief (and he makes the interesting observation that, for patients, symptoms often acquire the quality of a persecutory object) through clarification of external and internal conflicts, and on to fundamental psychological change that can include a change in personality. Relatedly, there is an emphasis on defining the goals of the patient and the goals of the therapist, which may differ at first but ideally begin to move toward a convergence.

Chapter 2 of *Interview and Indicators in Psychoanalysis and Psychotherapy* focuses on the techniques and dynamic of the first interview. The author explains that he uses the term *psychodynamic interview* rather than *psychoanalytic interview* because he is addressing not only analysts

but all mental health professionals. Although this is consistent with his desire to capture the interest of a wide audience, it also raises questions. I wonder, for instance, whether mental health professionals who are not psychoanalytically trained can be expected to conduct psychoanalytic interviews. In my experience, initial interviews require a great deal of analytic experience. The demands they place on the analyst are certainly not less than those needed to carry out a regular analytic session.

Moreover, I do not share Perez-Sanchez's related notion that a clear distinction must be made between the diagnostic phase and the beginning of the actual therapeutic process. In my opinion, the therapeutic or psychoanalytic process starts from the very beginning. It is also not unusual for the diagnostic phase to last much longer than the initial interviews. Elsewhere in the book, the author seems to take that view himself, which creates some confusion. I suspect this derives from the tension inherent in writing from a psychoanalytic perspective while aiming to reach a broader audience.

I wonder whether the author's approach, which he has taken since the 1990s, can actually succeed in stimulating greater interest in psychoanalysis and in psychoanalytic referrals and psychoanalytic training in particular. My own experience with this dual approach in institutions where multidisciplinary psychotherapy is practiced has not been positive. Promoting psychoanalysis by non-analysts may collapse due to ambivalence, envy, and a limited grasp of the psychoanalytic method.

Nevertheless, in chapter 2, Perez-Sanchez is clear and inspiring as he takes the reader on a tour through the main aspects of technique during initial interviews. He describes in detail the dynamics of the relationship, distinguishes between adult and childlike layers in the communication, and describes various aspects of meaningful nonverbal communication. Different types of interviews are organized according to the end goal (be it diagnostic, referral-oriented, or therapeutic) and the format (free or semi-structured).

"Aims of the Interview" is the title of the third chapter, which describes the different types of data that are important for diagnosis and treatment and the way in which they are collected. Perez-Sanchez assigns priority to the data that emerge within the framework of the relationship. Interestingly, he ascribes disadvantages to gathering extensive

data aimed at constructing a complete clinical history and biography. This leads him to the following statement: "The professional has a responsibility to try to achieve an adequate diagnostic assessment with the minimum possible data" (p. 53).

Missing from this chapter and the next one is attention to resistances against and fantasies about the proposed treatment. Besides the patient's resistances, the anxieties and ambivalence of the analyst are also important. This is a key factor in the initiation of psychoanalysis about which a number of authors have written. Rothstein, for example, is mentioned in Amati-Mehler's excellent preface to this book, but nowhere else in its pages. In the clinical examples, the patients described seem to be quite obedient; they follow whatever proposals for treatment are offered without much opposition or doubt. In my experience, things do not always go so smoothly, however.

Another crucial and omnipresent issue in the initial interview that is hardly addressed in the book is the analyst's financial remuneration. What about negotiation of the fee, third-party payments, and handling resistance about paying?

The clear and informative chapter 4 describes therapeutic factors at play during the initial interview. It contains interesting clinical examples that illustrate significant aspects of the transition from the diagnostic phase to the therapeutic phase. The premise is presented that, although these two phases can be distinguished from one another in terms of their purposes (diagnosis versus change that relieves suffering), they actually merge. The author calls them "two moments of the same process" (p. 81) that share the purpose of learning about the patient through observation. Elsewhere in the book, the term *participant observer* is used.

This brings me to another point: throughout the book, I had the feeling that the author oscillates between a one-person and a two-person psychological position. He pays relatively little attention to transference-countertransference constellations, and the analyst's emotional position seems neglected. The clinical vignettes also indicate a relatively short, *pre-established* duration of treatment: one year. This is consistently explained in terms of the patient's clinical situation, but I find myself wondering whether the therapist's countertransference to what was projected into him or her may also have played a role.

Such issues as countertransference, intersubjectivity, the relational view, and ambivalence and anxiety in the analyst are underexamined in the book as a whole, in fact, although they are not entirely missing. Other authors have considered such issues specifically in relation to initiating analysis; I think of Rothstein, Ogden, Busch, Ehrlich, Levine, and myself, as well as of the German-speaking authors who, using the concept of *Szenisch Verstehen* (which is close to the English term *enactment*), have contributed extensively to this subject.[3]

Perez-Sanchez's fifth chapter contains a detailed clinical report of several interviews. The sixth and seventh chapters address *psychodynamic indicators*—or, in the more usual phrasing, indication criteria. The author systematically provides a clear overview of the many factors that play a role in arriving at the most appropriate choice among various forms of psychoanalytic psychotherapy and psychoanalysis.

The author distinguishes between two approaches: the classical approach and the one relying on psychodynamic indicators. The classical approach includes well-known assessment criteria, such as motivation for change, capacity for self-observation, intact parts of the personality, a lack of predominating (self-)destructive tendencies, and the ability to form a working relationship based on mutual trust. Priority is placed on factors observed in the relationship. Such data obtained in the here and now serve as a reference point for other required data.

Despite his emphasis on the importance of the therapeutic relationship, however, I could not help forming the impression that, at the same time, Perez-Sanchez partly adheres to a form of thinking based on the medical model, in which the patient is essentially observed as an object providing information that indicates what disease is present. This approach focuses on the patient rather than on the dyad. The idea that indications for the appropriate form of treatment derive from the dynamics of the interaction is not entirely absent from the book, but remains in the background. The book would have gained more depth had this viewpoint been described more explicitly and an attempt made to integrate it with other perspectives discussed.

[3] For a thorough discussion of the initial consultation, see: Schubart, W. (1989). The patient in the psychoanalyst's consulting room: the first consultation as a psychoanalytic encounter. *Int. J. Psychoanal.,* 70:423-432.

The second approach, the one relying on psychodynamic indicators, feels newer than the first. The author emphasizes that these indicators do not provide an alternative to traditional criteria but are complementary to them. They are related to basic psychic ambivalence, viewed along a continuous spectrum. The patient's position between the poles of these contrasting indicators is important in making decisions about treatment. Paired indicators include: sick-sane, infantile-adult, sincerity-insincerity, love-hate of psychic truth, (tolerance for) pain-pleasure, separation-linking, and masculine-feminine.

Other important factors are the patient's response to the therapist's intervention, the capacity for containment within the social and family environment, and aspects of how the patient regards the therapist. The detailed discussion of this provides interesting reading but also raises questions. First is the choice of indicators on which to focus. Undoubtedly, all these phenomena are relevant, but are they sufficient? Why are such dimensions as love-hate, thinking-doing, progression-regression, and constructive versus destructive tendencies not given consideration as well?

The author has clearly given considerable thought to this, but the impression arises of a more or less arbitrary choice. I would also have liked to read more about how to evaluate and weigh these indicators in arriving at a more focused recommendation for the patient. The clinical examples provided do not adequately explain how the therapist eventually arrives at a particular recommendation or how it is conveyed to the patient.

Again in this chapter, too little attention is paid to the transference and especially to the countertransference—in my opinion, of major importance. My impression is that the therapist or analyst portrayed in this book is largely a (relatively nonparticipating) observer who generally aims to remain outside the interaction. In this regard, I was troubled by the assertion that a patient who is able to establish a cooperative attitude will be capable of doing so with any therapist. This is not my experience. Perez-Sanchez seems to view initiation of treatment as a process in which the patient is the sole variable and the therapist a constant, rather than consisting of an interaction between two people.

One of the highlights of the book is the penultimate chapter on the specificity of psychoanalysis and psychoanalytic psychotherapy. This is an important albeit complicated subject that has been widely discussed. It is not surprising, then, that Perez-Sanchez begins with a brief but clear outline of the history of this issue. After describing the aspects of theory and technique that analysis and analytic therapy share, he attempts to differentiate them. To this end, the author describes a line extending from psychoanalysis to psychoanalytic psychotherapy—to brief psychoanalytic psychotherapy, to supportive psychotherapy, and to a single therapeutic interview. He also considers the attitudes of therapist and patient, the therapist's interventions, and the forms of working through, as well as the physical positioning of therapist and patient. He creates a table that portrays the differences among psychoanalysis and the various forms of psychotherapy on a sliding scale. He emphasizes forms of working through, which are organized according to the width of the areas covered: "wide" in psychoanalysis, "zonal" in psychoanalytic psychotherapy, and "focal" in brief psychotherapy.

This arrangement and description do not provide new insights, but they do furnish a useful overview and stimulate the reader to think about the differences between psychoanalysis and psychotherapy. Although he describes a more or less sliding scale, the author does not indicate whether he conceptualizes it in terms of gradual or qualitative differences. He mentions that the frequency of sessions and the use of the couch are of lesser importance than interpretation of the transference, even though some consider session frequency and the use of the couch to be necessary ingredients in the psychoanalytic method. Perez-Sanchez thus seems to favor the position that there is an important qualitative distinction between the two methods.

Choosing between psychoanalysis and psychotherapy as the most appropriate mode of treatment is the subject of the final chapter. Perez-Sanchez mentions two factors that favor psychoanalysis over psychoanalytic psychotherapy: the presence of sufficient curiosity about oneself and the ability to work through the insight achieved, despite the pain and time it requires. I would add at least two other crucial considerations: namely, the depth and complexity of the pathology and the degree to which the patient is suffering from emotional pain. The first makes an intensive

approach such as psychoanalysis necessary, and the latter makes it endurable. The bulk of this chapter consists of a detailed clinical example.

Perez-Sanchez has written an accessible and interesting book that certainly fills a need. I enjoyed reading it, and I recommend it to others. The book has much to offer to less experienced psychoanalysts and psychoanalytic candidates, as it provides a broad overview of the topic at the same time that it offers deeper discussions of important issues. The experienced analyst will probably not find as much that is new in the book, although reading it can promote very useful thinking about the initiation of psychoanalysis. For psychoanalysts who may be finding it difficult to locate new analytic cases, Perez-Sanchez has provided a book that could be very helpful. I strongly recommend, however, that the reader examine other literature on the subject as well, so as to reach a more well-rounded view of the subject; it is a topic too important and too complex for any single book to be sufficiently comprehensive. I will close, therefore, with the beginning of a list of relevant readings that were published after the subject book and are supplementary to it.[4]

ROBBERT WILLE (HEEMSTEDE, THE NETHERLANDS)

THE PSYCHIC HOME: PSYCHOANALYSIS, CONSCIOUSNESS, AND THE HUMAN SOUL. By Roger Kennedy. Hove, UK/New York: Routledge, 2014. 159 pp.

What a distinctive pleasure it is to open a psychoanalytic book these days and be met by an author whose project it is to plumb the depths. Roger Kennedy does not offer us explanations or answers, but instead asks us to consider some of the most basic questions regarding what it means to be

[4] See the following: (1) Crick, P. (2014). Selecting a patient or initiating a psychoanalytic process? *Int. J. Psychoanal.,* 95:465-484; (2) Ehrlich, L. (2013). Analysis begins in the analyst's mind: conceptual and technical considerations on recommending analysis. *J. Amer. Psychoanal. Assn.,* 61:1077-1107; (3) Møller, M. (2014). The analyst's anxieties in the first interview: barriers against analytic presence. *Int. J. Psychoanal.,* 95:485-503; (4) Reith, B., Lagerlöf, S., Crick, P., Møller, M. & Skale, E. (2012). *Initiating Psychoanalysis: Perspectives*. London: Routledge; (5) Wegner, P. (2014). Process-oriented psychoanalytic work in initial interviews and the importance of the opening scene. *Int. J. Psychoanal.,* 95:505-523; and (6) Wille, R. (2012). The analyst's trust in psychoanalysis and the communication of that trust in initial interviews. *Psychoanal. Q.,* 81:875-904.

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human. His ambition is to consider what it is like to dwell in an interior psychic space—what psychoanalysts and some others would call having an inner life. In an age increasingly being taken over by technology, where psychology and psychiatry (at least in North America) are being thought in terms of efficiency, production, corporate goals, and chemical control, Kennedy reintroduces psychoanalysts to art and literature, to philosophy, architecture, and to religious notions of the soul. It is like coming home.

The notion of *home* frames this book in serious ways, both concrete and metaphorical. Kennedy asks us to consider the necessity of a home as a place of safety, consistency, and comfort. His survey of the importance of home touches on Bowlby and Winnicott, as might be expected, but also on Homer's myth of Odysseus, on architectural theory having to do with interior spaces, and on the poet-philosopher Bachelard, who wrote:

> There is ground for taking the house as a tool for analysis of the human soul . . . . Not only our memories, but the things we have forgotten are "housed." Our soul is an abode. And by remembering "houses" and "rooms," we learn to "abide" within ourselves. [Bachelard quoted by Kennedy, p. 14]

Kennedy develops these themes, teaching the reader a great deal about the historical emergence of private spaces in domestic dwellings from the seventeenth century to the present, and how these relate to trends in conceiving of individual subjects as having private interior spaces—intimate spaces about which one could become self-conscious.

Once the home (and the reconceived individual mind) was conceptualized as private and walled off into special and sometimes secret places, it was ripe for the introduction of themes concerning repression and neurosis. Enter Freud, who in the *Introductory Lectures on Psycho-Analysis* (1916–1917; *S. E.,* 15-16), employed—as Kennedy shows us—"the metaphor of a suite of rooms, a bourgeois interior, to explain the structure of the unconscious with an entrance hall, a drawing room, and a threshold in between" (p. 24).

Kennedy links these movements in historical conceptions of the subject to changes in painting that reflect, to his mind, "a new way of seeing the human subject, one in which the subject is beginning to look

inwards in a complex way" (p. 21). He feels this in his experience of a self-portrait by Rembrandt that graces the cover of this book. The author writes:

> As you contemplate a late Rembrandt self-portrait, his eyes seem to take you into the picture, into the depths. Unlike a mirror, which reflects your own image back to you, the Rembrandt urges you to reflect into yourself in the act of being drawn into his image. [p. 3]

Kennedy finds this experience, too, in the life and work of William Wordsworth, who wrote of "yearnings for home, loss of home, intense homecomings, homes that are ruined and may become a shelter for the homeless, and characters who have lost homes or who are homeless" (p. 34). In teaching the reader about Wordsworth's poetry, the author illustrates how places become emblematic of psychic space for the poet and stand in for attachments to loved others. Wordsworth's poems become a "living soul" wherein we find the organizing themes of the poet's subjective existence.

Ultimately, this is what Kennedy's book is about—the psychic homes we inhabit—the organizing structures of the mind, that is, that have to do with personal identity. Already one gets a sense here of the ephemeral quality of what Kennedy is trying to grasp as an experience: the mind, consciousness, the soul, interiority, identity. Not only are these experiences intensely private, but they are also elusive and indeterminate; and as such, they become the province of psychoanalytic attention for Kennedy—who, like any good tour guide, can point only to the scene of their occurrences and not to the things in themselves.

On the issue of identity, Kennedy plots a particularly interesting course. He treats the topic as complex and precarious, and, as is the case with his theoretical understanding of identity itself, he draws from various intellectual sources of influence but does not quite settle on one idea of what identity is. For Kennedy, identity is not static but always in process: "a matter of becoming as well as of being" (p. 46). He takes account of modern and postmodern themes concerning identity and of the political consequences of taking each position.

Kennedy plays well with the seeming consistency of identity in the face of change and the simultaneously paradoxical lack of a center of

identity, an ontic "thing" that abides change. In doing so, he traverses through philosophy (the work of John Locke, Paul Ricoeur, and Thomas Nagel, to give just three examples) and then takes up the varied ways in which analysts have conceived of the issue of identity.

What then, asks Kennedy, is the home of the soul? Moving from Plato to Foucault to St. Augustine, the author queries the residence of our human essence and the ways in which we have come to think about what a soul is. Is there a soul? Is there an inner essence?

Kennedy begins the chapter entitled "The Soul and Its Home" with a beautiful poem by Emily Dickinson that conceives the soul as a home. There's a *feeling of something recognizable and unique* in Dickinson's words, yet that feeling is just not something that can be located. Following a discussion of Plato and Aristotle, Kennedy quips: "One might talk of a human being providing a *home for the soul"* (p. 71, italics in original). That seems almost right to me, though I would put more of a Heideggerian spin on the issue and say that perhaps the soul is inextricably bound to being human (*Dasein*) in its sense of presence.

The soul—or consciousness, or the essence of our humanity—cannot be located in one region of the brain or another (as Kennedy illustrates in his discussion of the failure of neuroscience to solve what is called the "hard" problem of consciousness), any more than it can be located in the pineal gland. Kennedy observes that it was Freud who suggested there is something essentially elusive about our subjective life that makes it difficult to capture or unify. Why as analysts would we ever think, then, that neuroscience could provide the location of the soul or subject in an any more complete way than a poem by Dickinson or a self-portrait by Rembrandt might evoke? Why, when we believe in a Freudian unconscious whose hallmarks are ambiguity, uncertainty, and paradox, would we think that there was a center to our human being that would sit still for a moment?

Kennedy thinks instead that, from a psychological point of view:

> We call that which links with others the human soul. The live gaze, that which reflects back to the other, reveals the essence of a man, their character, their depth, their value, the "weight" of their soul, to use a rather medieval image. [pp. 141-142]

The two chapters that end the book—"Loneliness and Solitude" and "Happiness and Misery"—are not neat fits with the theme of the volume. It feels like something of a stretch to relate them to the issue of soul. What is most valuable here is Kennedy's treatment in the first of these chapters on the development of the analyst. It is a theme he touches on earlier in the volume in discussing the issue of identity and the perils of the analyst's own professional identifications. In this chapter, he discusses strains on us as working analysts—the loneliness inherent in our work, the effect of taking so much into ourselves, the narcissistic vulnerabilities, and the need to grow in significant personal ways in order to inwardly meet the needs of doing analytic work. There is very little written on the topic of the working analyst's development that is not about either beginning analysts or the potential bad behavior of analysts, and so Kennedy's treatment of these issues strikes me as extremely important.

There is not much new to discover in the final chapter, "Happiness and Misery." Kennedy cautions us not to pursue the fleeting experience of happiness, and he acknowledges the need for suffering in life. With the wisdom of a well-practiced analyst, he concludes:

> Psychoanalytic treatment cannot promise happiness, but may enable the patient to be relieved of excessive misery. The excessive demands of the superego will need to be tackled, but what the patient then does with a freer life is up to them. [p. 144]

BRUCE REIS (NEW YORK)