KONSTRUKTIONEN IN DER ANALYSE

(a) GERMAN EDITIONS:
1937 *Int. Z. Psychoanal.*, **23** (4), 459–69.
1950 *G.W.*, **16**, 43–56.

(b) ENGLISH TRANSLATION:
'Constructions in Analysis'
1938 *Int. J. Psycho-Anal.*, **19** (4), 377–87. (Tr. James Strachey.)
1950 *C.P.*, **5**, 358–71. (Revised reprint of above.)

The present translation is a corrected reprint of the one published in 1950.

This paper was published in December, 1937.

Though, as Freud remarks, constructions have received much less attention than interpretations in discussions of analytic technique, his own writings contain many allusions to them. There are two or three full-length examples of them in his case histories: in the 'Rat Man' analysis (1909*d*), *Standard Ed.*, **10**, 182 and 205, and in the 'Wolf Man' analysis (1918*b*). The whole latter case revolves around a construction; but the question is specifically discussed in Section V (*Standard Ed.*, **17**, 50 ff.). Finally, constructions played a large part in the case history of the homosexual girl (1920*a*), as is made plain in Section I (ibid., **18**, 152).

The paper ends with a discussion of a question in which Freud was much interested at this period—the distinction between what he described as 'historical' and 'material' truth.

CONSTRUCTIONS IN ANALYSIS

I

IT has always seemed to me to be greatly to the credit of a certain well-known man of science that he treated psychoanalysis fairly at a time when most other people felt themselves under no such obligation. On one occasion, nevertheless, he gave expression to an opinion upon analytic technique which was at once derogatory and unjust. He said that in giving interpretations to a patient we treat him upon the famous principle of 'Heads I win, tails you lose'.[1] That is to say, if the patient agrees with us, then the interpretation is right; but if he contradicts us, that is only a sign of his resistance, which again shows that we are right. In this way we are always in the right against the poor helpless wretch whom we are analysing, no matter how he may respond to what we put forward. Now, since it is in fact true that a 'No' from one of our patients is not as a rule enough to make us abandon an interpretation as incorrect, a revelation such as this of the nature of our technique has been most welcome to the opponents of analysis. It is therefore worth while to give a detailed account of how we are accustomed to arrive at an assessment of the 'Yes' or 'No' of our patients during analytic treatment—of their expression of agreement or of denial. The practising analyst will naturally learn nothing in the course of this apologia that he does not know already.[2]

It is familiar ground that the work of analysis aims at inducing the patient to give up the repressions (using the word in the widest sense) belonging to his early development and to replace them by reactions of a sort that would correspond to a psychically mature condition. With this purpose in view he must be brought to recollect certain experiences and the affective

[1] [In English in the original.]

[2] [This discussion takes up earlier ones in Freud's paper on 'Negation' (1925*h*), *Standard Ed.*, **19**, 235 and 239. Cf. also a passage in the first chapter of the 'Dora' analysis (1905*e*), ibid., **7**, 57 and a footnote added to the same passage in 1923; also a footnote to Chapter I (D) of the 'Rat Man' analysis (1909*d*), ibid., **10**, 183 *n.*]

impulses called up by them which he has for the time being forgotten. We know that his present symptoms and inhibitions are the consequences of repressions of this kind: thus that they are a substitute for these things that he has forgotten. What sort of material does he put at our disposal which we can make use of to put him on the way to recovering the lost memories? All kinds of things. He gives us fragments of these memories in his dreams, invaluable in themselves but seriously distorted as a rule by all the factors concerned in the formation of dreams. Again, he produces ideas, if he gives himself up to 'free association', in which we can discover allusions to the repressed experiences and derivatives of the suppressed affective impulses as well as of the reactions against them. And, finally, there are hints of repetitions of the affects belonging to the repressed material to be found in actions performed by the patient, some fairly important, some trivial, both inside and outside the analytic situation. Our experience has shown that the relation of transference, which becomes established towards the analyst, is particularly calculated to favour the return of these emotional connections. It is out of such raw material—if we may so describe it—that we have to put together what we are in search of.

What we are in search of is a picture of the patient's forgotten years that shall be alike trustworthy and in all essential respects complete. But at this point we are reminded that the work of analysis consists of two quite different portions, that it is carried on in two separate localities, that it involves two people, to each of whom a distinct task is assigned. It may for a moment seem strange that such a fundamental fact should not have been pointed out long ago; but it will immediately be perceived that there was nothing being kept back in this, that it is a fact which is universally known and, as it were, self-evident and is merely being brought into relief here and separately examined for a particular purpose. We all know that the person who is being analysed has to be induced to remember something that has been experienced by him and repressed; and the dynamic determinants of this process are so interesting that the other portion of the work, the task performed by the analyst, has been pushed into the background. The analyst has neither experienced nor repressed any of the material under consideration; his task cannot be to remember anything. What then *is* his task? His task is to make out what has been forgotten from the traces which it has left behind or, more correctly, to *construct* it. The time and manner in which he conveys his constructions to the person who is being analysed, as well as the explanations with which he accompanies them, constitute the link between the two portions of the work of analysis, between his own part and that of the patient.

His work of construction, or, if it is preferred, of reconstruction, resembles to a great extent an archaeologist's excavation of some dwelling-place that has been destroyed and buried or of some ancient edifice. The two processes are in fact identical, except that the analyst works under better conditions and has more material at his command to assist him, since what he is dealing with is not something destroyed but something that is still alive—and perhaps for another reason as well. But just as the archaeologist builds up the walls of the building from the foundations that have remained standing, determines the number and position of the columns from depressions in the floor and reconstructs the mural decorations and paintings from the remains found in the débris, so does the analyst proceed when he draws his inferences from the fragments of memories, from the associations and from the behaviour of the subject of the analysis. Both of them have an undisputed right to reconstruct by means of supplementing and combining the surviving remains. Both of them, moreover, are subject to many of the same difficulties and sources of error. One of the most ticklish problems that confronts the archaeologist is notoriously the determination of the relative age of his finds; and if an object makes its appearance in some particular level, it often remains to be decided whether it belongs to that level or whether it was carried down to that level owing to some subsequent disturbance. It is easy to imagine the corresponding doubts that arise in the case of analytic constructions.

The analyst, as we have said, works under more favourable conditions than the archaeologist since he has at his disposal material which can have no counterpart in excavations, such as the repetitions of reactions dating from infancy and all that is indicated by the transference in connection with these repetitions. But in addition to this it must be borne in mind that the excavator is dealing with destroyed objects of which large and important portions have quite certainly been lost, by mechanical violence, by fire and by plundering. No amount of effort

can result in their discovery and lead to their being united with the surviving remains. The one and only course open is that of reconstruction, which for this reason can often reach only a certain degree of probability. But it is different with the psychical object whose early history the analyst is seeking to recover. Here we are regularly met by a situation which with the archaeological object occurs only in such rare circumstances as those of Pompeii or of the tomb of Tut'ankhamun. All of the essentials are preserved; even things that seem completely forgotten are present somehow and somewhere, and have merely been buried and made inaccessible to the subject. Indeed, it may, as we know, be doubted whether any psychical structure can really be the victim of total destruction. It depends only upon analytic technique whether we shall succeed in bringing what is concealed completely to light. There are only two other facts that weigh against the extraordinary advantage which is thus enjoyed by the work of analysis: namely, that psychical objects are incomparably more complicated than the excavator's material ones and that we have insufficient knowledge of what we may expect to find, since their finer structure contains so much that is still mysterious. But our comparison between the two forms of work can go no further than this; for the main difference between them lies in the fact that for the archaeologist the reconstruction is the aim and end of his endeavours while for analysis the construction is only a preliminary labour.

II

It is not, however, a preliminary labour in the sense that the whole of it must be completed before the next piece of work can be begun, as, for instance, is the case with house-building, where all the walls must be erected and all the windows inserted before the internal decoration of the rooms can be taken in hand. Every analyst knows that things happen differently in an analytic treatment and that there both kinds of work are carried on side by side, the one kind being always a little ahead and the other following upon it. The analyst finishes a piece of construction and communicates it to the subject of the analysis so that it may work upon him; he then constructs a further piece out of the fresh material pouring in upon him, deals with it in the same way and proceeds in this alternating fashion until

the end. If, in accounts of analytic technique, so little is said about 'constructions', that is because 'interpretations' and their effects are spoken of instead. But I think that 'construction' is by far the more appropriate description. 'Interpretation' applies to something that one does to some single element of the material, such as an association or a parapraxis. But it is a 'construction' when one lays before the subject of the analysis a piece of his early history that he has forgotten, in some such way as this: 'Up to your *n*th year you regarded yourself as the sole and unlimited possessor of your mother; then came another baby and brought you grave disillusionment. Your mother left you for some time, and even after her reappearance she was never again devoted to you exclusively. Your feelings towards your mother became ambivalent, your father gained a new importance for you,' . . . and so on.

In the present paper our attention will be turned exclusively to this preliminary labour performed by constructions. And here, at the very start, the question arises of what guarantee we have while we are working on these constructions that we are not making mistakes and risking the success of the treatment by putting forward some construction that is incorrect. It may seem that no general reply can in any event be given to this question; but even before discussing it we may lend our ear to some comforting information that is afforded by analytic experience. For we learn from it that no damage is done if, for once in a way, we make a mistake and offer the patient a wrong construction as the probable historical truth. A waste of time is, of course, involved, and anyone who does nothing but present the patient with false combinations will neither create a very good impression on him nor carry the treatment very far; but a single mistake of the sort can do no harm.[1] What in fact occurs in such an event is rather that the patient remains as though he were untouched by what has been said and reacts to it with neither a 'Yes' nor a 'No'. This may possibly mean no more than that his reaction is postponed; but if nothing further develops we may conclude that we have made a mistake and we shall admit as much to the patient at some suitable opportunity without sacrificing any

[1] [An example of an incorrect construction is mentioned at the beginning of Section III of the 'Wolf Man' case history (1918*b*), *Standard Ed.*, **17**, 19.]

of our authority. Such an opportunity will arise when some new material has come to light which allows us to make a better construction and so to correct our error. In this way the false construction drops out, as if it had never been made; and, indeed, we often get an impression as though, to borrow the words of Polonius, our bait of falsehood had taken a carp of truth. The danger of our leading a patient astray by suggestion, by persuading him to accept things which we ourselves believe but which he ought not to, has certainly been enormously exaggerated. An analyst would have had to behave very incorrectly before such a misfortune could overtake him; above all, he would have to blame himself with not allowing his patients to have their say. I can assert without boasting that such an abuse of 'suggestion' has never occurred in my practice.

It already follows from what has been said that we are not at all inclined to neglect the indications that can be inferred from the patient's reaction when we have offered him one of our constructions. The point must be gone into in detail. It is true that we do not accept the 'No' of a person under analysis at its face value; but neither do we allow his 'Yes' to pass. There is no justification for accusing us of invariably twisting his remarks into a confirmation. In reality things are not so simple and we do not make it so easy for ourselves to come to a conclusion.

A plain 'Yes' from a patient is by no means unambiguous. It can indeed signify that he recognizes the correctness of the construction that has been presented to him; but it can also be meaningless, or can even deserve to be described as 'hypocritical', since it may be convenient for his resistance to make use of an assent in such circumstances in order to prolong the concealment of a truth that has not been discovered. The 'Yes' has no value unless it is followed by indirect confirmations, unless the patient, immediately after his 'Yes', produces new memories which complete and extend the construction. Only in such an event do we consider that the 'Yes' has dealt completely with the subject under discussion.[1]

A 'No' from a person in analysis is quite as ambiguous as a 'Yes', and is indeed of even less value. In some rare cases it turns out to be the expression of a legitimate dissent. Far more

[1] [Cf. a paragraph in Section VII of 'Remarks on the Theory and Practice of Dream-Interpretation' (1923*c*), *Standard Ed.*, **19**, 115.]

frequently it expresses a resistance which may have been evoked by the subject-matter of the construction that has been put forward but which may just as easily have arisen from some other factor in the complex analytic situation. Thus, a patient's 'No' is no evidence of the correctness of a construction, though it is perfectly compatible with it. Since every such construction is an incomplete one, since it covers only a small fragment of the forgotten events, we are free to suppose that the patient is not in fact disputing what has been said to him but is basing his contradiction upon the part that has not yet been uncovered. As a rule he will not give his assent until he has learnt the whole truth—which often covers a very great deal of ground. So that the only safe interpretation of his 'No' is that it points to incompleteness; there can be no doubt that the construction has not told him everything.

It appears, therefore, that the direct utterances of the patient after he has been offered a construction afford very little evidence upon the question whether we have been right or wrong. It is of all the greater interest that there are indirect forms of confirmation which are in every respect trustworthy. One of these is a form of words that is used (as though by general agreement) with very little variation by the most different people: 'I didn't ever think' (or 'I shouldn't ever have thought') 'that' (or 'of that').[1] This can be translated without any hesitation into: 'Yes, you're right this time—about my *unconscious*.' Unfortunately this formula, which is so welcome to the analyst, reaches his ears more often after single interpretations than after he has produced an extensive construction. An equally valuable confirmation is implied (expressed this time positively) when the patient answers with an association which contains something similar or analogous to the content of the construction. Instead of taking an example of this from an analysis (which would be easy to find but lengthy to describe) I prefer to give an account of a small extra-analytical experience which presents a similar situation so strikingly that it produces an almost comic effect. It concerned one of my colleagues who—it was long ago—had chosen me as a consultant in his medical practice. One day, however, he brought his young wife to see me, as she was causing him trouble. She refused on all sorts of

[1] [Almost exactly the same phrases occur at the end of the paper on 'Negation' (1925*h*), *Standard Ed.*, **19**, 239.]

pretexts to have sexual relations with him, and what he expected of me was evidently that I should lay before her the consequences of her ill-advised behaviour. I went into the matter and explained to her that her refusal would probably have unfortunate results for her husband's health or would lay him open to temptations that might lead to a break-up of their marriage. At this point he suddenly interrupted me with the remark: 'The Englishman you diagnosed as suffering from a cerebral tumour has died too.' At first the remark seemed incomprehensible; the 'too' in his sentence was a mystery, for we had not been speaking of anyone else who had died. But a short time afterwards I understood. The man was evidently intending to confirm what I had been saying; he was meaning to say: 'Yes, you're certainly quite right. Your diagnosis was confirmed in the case of the other patient too.' It was an exact parallel to the indirect confirmations that we obtain in analysis from associations. I will not attempt to deny that there were other thoughts as well, put on one side by my colleague, which had a share in determining his remark.

Indirect confirmation from associations that fit in with the content of a construction—that give us a 'too' like the one in my story—provides a valuable basis for judging whether the construction is likely to be confirmed in the course of the analysis. It is particularly striking when, by means of a parapraxis, a confirmation of this kind insinuates itself into a direct denial. I once published elsewhere a nice example of this.[1] The name 'Jauner' (a familiar one in Vienna) came up repeatedly in one of my patient's dreams without a sufficient explanation appearing in his associations. I finally put forward the interpretation that when he said 'Jauner' he probably meant 'Gauner' [swindler], whereupon he promptly replied: 'That seems to me too "*jewagt*" [instead of "gewagt" (far-fetched)].'[2] Or there was the other instance, in which, when I suggested to a patient that he considered a particular fee too high, he meant to deny the suggestion with the words 'Ten dollars mean nothing to me' but instead of dollars put in a coin of lower value and said 'ten shillings'.

[1] [See the next footnote.]

[2] [Chapter V of *The Psychopathology of Everyday Life* (1901*b*), *Standard Ed.*, **6**, 94. In vulgar speech the 'g' is often pronounced like the German 'j' (English 'y').]

If an analysis is dominated by powerful factors that impose a negative therapeutic reaction,[1] such as a sense of guilt, a masochistic need for suffering or repugnance to receiving help from the analyst, the patient's behaviour after he has been offered a construction often makes it very easy for us to arrive at the decision that we are in search of. If the construction is wrong, there is no change in the patient; but if it is right or gives an approximation to the truth, he reacts to it with an unmistakable aggravation of his symptoms and of his general condition.

We may sum the matter up by asserting that there is no justification for the reproach that we neglect or underestimate the importance of the attitude taken up by those under analysis towards our constructions. We pay attention to them and often derive valuable information from them. But these reactions on the part of the patient are rarely unambiguous and give no opportunity for a final judgement. Only the further course of the analysis enables us to decide whether our constructions are correct or unserviceable. We do not pretend that an individual construction is anything more than a conjecture which awaits examination, confirmation or rejection. We claim no authority for it, we require no direct agreement from the patient, nor do we argue with him if at first he denies it. In short, we conduct ourselves on the model of a familiar figure in one of Nestroy's farces[2]—the manservant who has a single answer on his lips to every question or objection: 'It will all become clear in the course of future developments.'

III

How this occurs in the process of the analysis—the way in which a conjecture of ours is transformed into the patient's conviction—this is hardly worth describing. All of it is familiar to every analyst from his daily experience and is intelligible without difficulty. Only one point requires investigation and explanation. The path that starts from the analyst's construction ought to end in the patient's recollection; but it does not always lead so far. Quite often we do not succeed in bringing the patient to recollect what has been repressed. Instead of that, if

[1] [Cf. Chapter V of *The Ego and the Id* (1923*b*), ibid., **19**, 49.]

[2] [*Der Zerrissene.*]

the analysis is carried out correctly, we produce in him an assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory. The problem of what the circumstances are in which this occurs and of how it is possible that what appears to be an incomplete substitute should nevertheless produce a complete result—all of this is matter for a later enquiry.

I shall conclude this brief paper with a few remarks which open up a wider perspective. I have been struck by the manner in which, in certain analyses, the communication of an obviously apt construction has evoked in the patients a surprising and at first incomprehensible phenomenon. They have had lively recollections called up in them—which they themselves have described as 'ultra-clear'[1]—but what they have recollected has not been the event that was the subject of the construction but details relating to that subject. For instance, they have recollected with abnormal sharpness the faces of the people involved in the construction or the rooms in which something of the sort might have happened, or, a step further away, the furniture in such rooms—on the subject of which the construction had naturally no possibility of any knowledge. This has occurred both in dreams immediately after the construction had been put forward and in waking states resembling phantasies. These recollections have themselves led to nothing further and it has seemed plausible to regard them as the product of a compromise. The 'upward drive' of the repressed, stirred into activity by the putting forward of the construction, has striven to carry the important memory-traces into consciousness; but a resistance has succeeded, not, it is true, in *stopping* that movement, but in *displacing* it on to adjacent objects of minor significance.

These recollections might have been described as hallucinations if a belief in their actual presence had been added to their clearness. The importance of this analogy seemed greater when

[1] [The phenomenon here described seems to go back to observations made by Freud in connection with *The Psychopathology of Everyday Life* (1901*b*). See the long footnote, *Standard Ed.*, **4**, 18. The present passage may even be an allusion to a particular episode narrated there, ibid., 266–7. Cf. also the still earlier papers on 'The Psychical Mechanism of Forgetfulness' (1898*b*), ibid., **3**, 290–1 and footnote, and 297, and on 'Screen Memories' (1899*a*), ibid., **3**, 312–13. In all these passages Freud uses the same word '*überdeutlich*', translated here 'ultra-clear'.]

I noticed that true hallucinations occasionally occurred in the case of other patients who were certainly not psychotic. My line of thought proceeded as follows. Perhaps it may be a general characteristic of hallucinations to which sufficient attention has not hitherto been paid that in them something that has been experienced in infancy and then forgotten returns—something that the child has seen or heard at a time when he could still hardly speak and that now forces its way into consciousness, probably distorted and displaced owing to the operation of forces that are opposed to this return. And, in view of the close relation between hallucinations and particular forms of psychosis, our line of thought may be carried still further. It may be that the delusions into which these hallucinations are so constantly incorporated may themselves be less independent of the upward drive of the unconscious and the return of the repressed than we usually assume. In the mechanism of a delusion we stress as a rule only two factors: the turning away from the real world and its motive forces on the one hand, and the influence exercised by wish-fulfilment on the content of the delusion on the other. But may it not be that the dynamic process is rather that the turning away from reality is exploited by the upward drive of the repressed in order to force its content into consciousness, while the resistances stirred up by this process and the trend to wish-fulfilment share the responsibility for the distortion and displacement of what is recollected? This is after all the familiar mechanism of dreams, which intuition has equated with madness from time immemorial.

This view of delusions is not, I think, entirely new, but it nevertheless emphasizes a point of view which is not usually brought into the foreground. The essence of it is that there is not only *method* in madness, as the poet has already perceived, but also a fragment of *historical truth*; and it is plausible to suppose that the compulsive belief attaching to delusions derives its strength precisely from infantile sources of this kind. All that I can produce to-day in support of this theory are reminiscences, not fresh impressions. It would probably be worth while to make an attempt to study cases of the disorder in question on the basis of the hypotheses that have been here put forward and also to carry out their treatment on those same lines. The vain effort would be abandoned of convincing

the patient of the error of his delusion and of its contradiction of reality; and, on the contrary, the recognition of its kernel of truth would afford common ground upon which the therapeutic work could develop. That work would consist in liberating the fragment of historical truth from its distortions and its attachments to the actual present day and in leading it back to the point in the past to which it belongs. The transposing of material from a forgotten past on to the present or on to an expectation of the future is indeed a habitual occurrence in neurotics no less than in psychotics. Often enough, when a neurotic is led by an anxiety-state to expect the occurrence of some terrible event, he is in fact merely under the influence of a repressed memory (which is seeking to enter consciousness but cannot become conscious) that something which was at that time terrifying did really happen. I believe that we should gain a great deal of valuable knowledge from work of this kind upon psychotics even if it led to no therapeutic success.

I am aware that it is of small service to handle so important a subject in the cursory fashion that I have here employed. But none the less I have not been able to resist the seduction of an analogy. The delusions of patients appear to me to be the equivalents of the constructions which we build up in the course of an analytic treatment—attempts at explanation and cure, though it is true that these, under the conditions of a psychosis, can do no more than replace the fragment of reality that is being disavowed in the present by another fragment that had already been disavowed in the remote past. It will be the task of each individual investigation to reveal the intimate connections between the material of the present disavowal and that of the original repression. Just as our construction is only effective because it recovers a fragment of lost experience, so the delusion owes its convincing power to the element of historical truth which it inserts in the place of the rejected reality. In this way a proposition which I originally asserted only of hysteria would apply also to delusions—namely, that those who are subject to them are suffering from their own reminiscences.[1] I never intended by this short formula to dispute the complexity of the causation of the illness or to exclude the operation of many other factors.

[1] [Cf. the Breuer and Freud 'Preliminary Communication' (1893*a*), *Standard Ed.*, **2**, 7.]

If we consider mankind as a whole and substitute it for the single human individual, we discover that it too has developed delusions which are inaccessible to logical criticism and which contradict reality. If, in spite of this, they are able to exert an extraordinary power over men, investigation leads us to the same explanation as in the case of the single individual. They owe their power to the element of *historical truth* which they have brought up from the repression of the forgotten and primaeval past.[1]

[1] [The topic of the last few paragraphs ('historical' truth) was very much in Freud's mind at this period, and this was his first long discussion of it. A full list of other references to it will be found in a footnote to the Section of *Moses and Monotheism* (1939*a*) dealing with the same question (p. 130 above).]

BEMERKUNGEN ÜBER DIE ÜBERTRAGUNGSLIEBE

(*a*) GERMAN EDITIONS:

1915 *Int. Z. Psychoanal.*, 3 (1), 1–11.
1918 *S.K.S.N.*, 4, 453–69. (1922, 2nd ed.)
1924 *Technik und Metapsychol.*, 120–35.
1925 *G.S.*, 6, 120–35.
1931 *Neurosenlehre und Technik*, 385–96.
1946 *G.W.*, 10, 306–21.

(*b*) ENGLISH TRANSLATION:

'Further Recommendations in the Technique of Psycho-Analysis: Observations on Transference-Love'
1924 *C.P.*, 2, 377–91. (Tr. Joan Riviere.)

The present translation, with a changed title, is a modified version of the one published in 1924.

When this paper was first published (early in 1915), its title ran: 'Weitere Ratschläge zur Technik der Psychoanalyse (III): Bemerkungen über die Übertragungsliebe.' The title of the English translation of 1924, as given above, is a rendering of this. The German editions from 1924 onwards adopted the shorter title.

Dr. Ernest Jones tells us (1955, 266) that Freud considered this the best of the present series of technical papers. A letter written by Freud to Ferenczi on December 13, 1931, in connection with the technical innovations introduced by the latter, forms an interesting postscript to this paper. It was published by Dr. Jones towards the end of Chapter IV of his third volume of Freud's biography (1957, 174 ff.).

Freud

OBSERVATIONS ON TRANSFERENCE-LOVE

(FURTHER RECOMMENDATIONS ON THE TECHNIQUE OF PSYCHO-ANALYSIS III)

EVERY beginner in psycho-analysis probably feels alarmed at first at the difficulties in store for him when he comes to interpret the patient's associations and to deal with the reproduction of the repressed. When the time comes, however, he soon learns to look upon these difficulties as insignificant, and instead becomes convinced that the only really serious difficulties he has to meet lie in the management of the transference.

Among the situations which arise in this connection I shall select one which is very sharply circumscribed; and I shall select it, partly because it occurs so often and is so important in its real aspects and partly because of its theoretical interest. What I have in mind is the case in which a woman patient shows by unmistakable indications, or openly declares, that she has fallen in love, as any other mortal woman might, with the doctor who is analysing her. This situation has its distressing and comical aspects, as well as its serious ones. It is also determined by so many and such complicated factors, it is so unavoidable and so difficult to clear up, that a discussion of it to meet a vital need of analytic technique has long been overdue. But since we who laugh at other people's failings are not always free from them ourselves, we have not so far been precisely in a hurry to fulfil this task. We are constantly coming up against the obligation to professional discretion—a discretion which cannot be dispensed with in real life, but which is of no service in our science. In so far as psycho-analytic publications are a part of real life, too, we have here an insoluble contradiction. I have recently disregarded this matter of discretion at one point,[1] and shown how this same transference situation held back the development of psycho-analytic therapy during its first decade.

[1] In the first section of my contribution to the history of the psycho-analytic movement (1914*d*). [This refers to Breuer's difficulties over the transference in the case of Anna O. (*Standard Ed.*, 14, 12).]

To a well-educated layman (for that is what the ideal civilized person is in regard to psycho-analysis) things that have to do with love are incommensurable with everything else; they are, as it were, written on a special page on which no other writing is tolerated. If a woman patient has fallen in love with her doctor it seems to such a layman that only two outcomes are possible. One, which happens comparatively rarely, is that all the circumstances allow of a permanent legal union between them; the other, which is more frequent, is that the doctor and the patient part and give up the work they have begun which was to have led to her recovery, as though it had been interrupted by some elemental phenomenon. There is, to be sure, a third conceivable outcome, which even seems compatible with a continuation of the treatment. This is that they should enter into a love-relationship which is illicit and which is not intended to last for ever. But such a course is made impossible by conventional morality and professional standards. Nevertheless, our layman will beg the analyst to reassure him as unambiguously as possible that this third alternative is excluded.

It is clear that a psycho-analyst must look at things from a different point of view.

Let us take the case of the second outcome of the situation we are considering. After the patient has fallen in love with her doctor, they part; the treatment is given up. But soon the patient's condition necessitates her making a second attempt at analysis, with another doctor. The next thing that happens is that she feels she has fallen in love with this second doctor too; and if she breaks off with him and begins yet again, the same thing will happen with the third doctor, and so on. This phenomenon, which occurs without fail and which is, as we know, one of the foundations of the psycho-analytic theory, may be evaluated from two points of view, that of the doctor who is carrying out the analysis and that of the patient who is in need of it.

For the doctor the phenomenon signifies a valuable piece of enlightenment and a useful warning against any tendency to a counter-transference which may be present in his own mind.[1] He must recognize that the patient's falling in love is induced

[1] [The question of the 'counter-transference' had already been raised by Freud in his Nuremberg Congress paper (1910*d*), *Standard Ed.*, 11, 144–5. He returns to it below, on pp. 165 f. and 169 f. Apart from these passages, it is hard to find any other explicit discussions of the subject in Freud's published works.]

by the analytic situation and is not to be attributed to the charms of his own person; so that he has no grounds whatever for being proud of such a 'conquest', as it would be called outside analysis. And it is always well to be reminded of this. For the patient, however, there are two alternatives: either she must relinquish psycho-analytic treatment or she must accept falling in love with her doctor as an inescapable fate.[1]

I have no doubt that the patient's relatives and friends will decide as emphatically for the first of these two alternatives as the analyst will for the second. But I think that here is a case in which the decision cannot be left to the tender—or rather, the egoistic and jealous—concern of her relatives. The welfare of the patient alone should be the touchstone; her relatives' love cannot cure her neurosis. The analyst need not push himself forward, but he may insist that he is indispensable for the achievement of certain ends. Any relative who adopts Tolstoy's attitude to this problem can remain in undisturbed possession of his wife or daughter; but he will have to try to put up with the fact that she, for her part, retains her neurosis and the interference with her capacity for love which it involves. The situation, after all, is similar to that in a gynaecological treatment. Moreover, the jealous father or husband is greatly mistaken if he thinks that the patient will escape falling in love with her doctor if he hands her over to some kind of treatment other than analysis for combating her neurosis. The difference, on the contrary, will only be that a love of this kind, which is bound to remain unexpressed and unanalysed, can never make the contribution to the patient's recovery which analysis would have extracted from it.

It has come to my knowledge that some doctors who practise analysis frequently[2] prepare their patients for the emergence of the erotic transference or even urge them to 'go ahead and fall in love with the doctor so that the treatment may make progress'. I can hardly imagine a more senseless proceeding.

[1] We know that the transference can manifest itself in other, less tender feelings, but I do not propose to go into that side of the matter here. [See the paper on 'The Dynamics of Transference' (1912*b*), p. 105 above.]

[2] ['*Häufig.*' In the first edition only, the word here is '*frühzeitig*' ('early').]

In doing so, an analyst robs the phenomenon of the element of spontaneity which is so convincing and lays up obstacles for himself in the future which are hard to overcome.[1]

At a first glance it certainly does not look as if the patient's falling in love in the transference could result in any advantage to the treatment. No matter how amenable she has been up till then, she suddenly loses all understanding of the treatment and all interest in it, and will not speak or hear about anything but her love, which she demands to have returned. She gives up her symptoms or pays no attention to them; indeed, she declares that she is well. There is a complete change of scene; it is as though some piece of make-believe had been stopped by the sudden irruption of reality—as when, for instance, a cry of fire is raised during a theatrical performance. No doctor who experiences this for the first time will find it easy to retain his grasp on the analytic situation and to keep clear of the illusion that the treatment is really at an end.

A little reflection enables one to find one's bearings. First and foremost, one keeps in mind the suspicion that anything that interferes with the continuation of the treatment may be an expression of resistance.[2] There can be no doubt that the outbreak of a passionate demand for love is largely the work of resistance. One will have long since noticed in the patient the signs of an affectionate transference, and one will have been able to feel certain that her docility, her acceptance of the analytic explanations, her remarkable comprehension and the high degree of intelligence she showed were to be attributed to this attitude towards her doctor. Now all this is swept away. She has become quite without insight and seems to be swallowed up in her love. Moreover, this change quite regularly occurs precisely at a point of time when one is having to try to bring her to admit or remember some particularly distressing and heavily repressed piece of her life-history. She has been in love, therefore, for a long time; but now the resistance is beginning to make use of her love in order to hinder the continuation of

[1] [In the first edition only, this paragraph (which is in the nature of a parenthesis) was printed in small type.]

[2] [Freud had already stated this still more categorically in the first edition of *The Interpretation of Dreams* (1900*a*), *Standard Ed.*, 5, 517. But in 1925 he added a long footnote to the passage, explaining its sense and qualifying the terms in which he had expressed himself.]

the treatment, to deflect all her interest from the work and to put the analyst in an awkward position.

If one looks into the situation more closely one recognizes the influence of motives which further complicate things—of which some are connected with being in love and others are particular expressions of resistance. Of the first kind are the patient's endeavour to assure herself of her irresistibility, to destroy the doctor's authority by bringing him down to the level of a lover and to gain all the other promised advantages incidental to the satisfaction of love. As regards the resistance, we may suspect that on occasion it makes use of a declaration of love on the patient's part as a means of putting her analyst's severity to the test, so that, if he should show signs of compliance, he may expect to be taken to task for it. But above all, one gets an impression that the resistance is acting as an *agent provocateur*; it heightens the patient's state of being in love and exaggerates her readiness for sexual surrender in order to justify the workings of repression all the more emphatically, by pointing to the dangers of such licentiousness.[1] All these accessory motives, which in simpler cases may not be present, have, as we know, been regarded by Adler as the essential part of the whole process.[2]

But how is the analyst to behave in order not to come to grief over this situation, supposing he is convinced that the treatment should be carried on in spite of this erotic transference and should take it in its stride?

It would be easy for me to lay stress on the universally accepted standards of morality and to insist that the analyst must never under any circumstances accept or return the tender feelings that are offered him: that, instead, he must consider that the time has come for him to put before the woman who is in love with him the demands of social morality and the necessity for renunciation, and to succeed in making her give up her desires, and, having surmounted the animal side of her self, go on with the work of analysis.

I shall not, however, fulfil these expectations—neither the first nor the second of them. Not the first, because I am writing not for patients but for doctors who have serious difficulties to contend with, and also because in this instance I am able to trace the moral prescription back to its source, namely to

[1] [Cf. pp. 152–3.]

expediency. I am on this occasion in the happy position of being able to replace the moral embargo by considerations of analytic technique, without any alteration in the outcome.

Even more decidedly, however, do I decline to fulfil the second of the expectations I have mentioned. To urge the patient to suppress, renounce or sublimate her instincts the moment she has admitted her erotic transference would be, not an analytic way of dealing with them, but a senseless one. It would be just as though, after summoning up a spirit from the underworld by cunning spells, one were to send him down again without having asked him a single question. One would have brought the repressed into consciousness, only to repress it once more in a fright. Nor should we deceive ourselves about the success of any such proceeding. As we know, the passions are little affected by sublime speeches. The patient will feel only the humiliation, and she will not fail to take her revenge for it.

Just as little can I advocate a middle course, which would recommend itself to some people as being specially ingenious. This would consist in declaring that one returns the patient's fond feelings but at the same time in avoiding any physical implementation of this fondness until one is able to guide the relationship into calmer channels and raise it to a higher level. My objection to this expedient is that psycho-analytic treatment is founded on truthfulness. In this fact lies a great part of its educative effect and its ethical value. It is dangerous to depart from this foundation. Anyone who has become saturated in the analytic technique will no longer be able to make use of the lies and pretences which a doctor normally finds unavoidable; and if, with the best intentions, he does attempt to do so, he is very likely to betray himself. Since we demand strict truthfulness from our patients, we jeopardize our whole authority if we let ourselves be caught out by them in a departure from the truth. Besides, the experiment of letting oneself go a little way in tender feelings for the patient is not altogether without danger. Our control over ourselves is not so complete that we may not suddenly one day go further than we had intended. In my opinion, therefore, we ought not to give up the neutrality towards the patient, which we have acquired through keeping the counter-transference in check.

I have already let it be understood that analytic technique

requires of the physician that he should deny to the patient who is craving for love the satisfaction she demands. The treatment must be carried out in abstinence. By this I do not mean physical abstinence alone, nor yet the deprivation of everything that the patient desires, for perhaps no sick person could tolerate this. Instead, I shall state it as a fundamental principle that the patient's need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes, and that we must beware of appeasing those forces by means of surrogates. And what we could offer would never be anything else than a surrogate, for the patient's condition is such that, until her repressions are removed, she is incapable of getting real satisfaction.

Let us admit that this fundamental principle of the treatment being carried out in abstinence extends far beyond the single case we are considering here, and that it needs to be thoroughly discussed in order that we may define the limits of its possible application.[1] We will not enter into this now, however, but will keep as close as possible to the situation from which we started out. What would happen if the doctor were to behave differently and, supposing both parties were free, if he were to avail himself of that freedom in order to return the patient's love and to still her need for affection?

If he has been guided by the calculation that this compliance on his part will ensure his domination over his patient and thus enable him to influence her to perform the tasks required by the treatment, and in this way to liberate herself permanently from her neurosis—then experience would inevitably show him that his calculation was wrong. The patient would achieve *her* aim, but he would never achieve *his*. What would happen to the doctor and the patient would only be what happened, according to the amusing anecdote, to the pastor and the insurance agent. The insurance agent, a free-thinker, lay at the point of death and his relatives insisted on bringing in a man of God to convert him before he died. The interview lasted so long that those who were waiting outside began to have hopes. At last the door of the sick-chamber opened. The free-thinker had not been converted; but the pastor went away insured.

[1] [Freud took this subject up again in his Budapest Congress paper (1919*a*), *Standard Ed.*, **17**, 162–3.]

If the patient's advances were returned it would be a great triumph for her, but a complete defeat for the treatment. She would have succeeded in what all patients strive for in analysis —she would have succeeded in acting out, in repeating in real life, what she ought only to have remembered, to have reproduced as psychical material and to have kept within the sphere of psychical events.[1] In the further course of the love-relationship she would bring out all the inhibitions and pathological reactions of her erotic life, without there being any possibility of correcting them; and the distressing episode would end in remorse and a great strengthening of her propensity to repression. The love-relationship in fact destroys the patient's susceptibility to influence from analytic treatment. A combination of the two would be an impossibility.

It is, therefore, just as disastrous for the analysis if the patient's craving for love is gratified as if it is suppressed. The course the analyst must pursue is neither of these; it is one for which there is no model in real life. He must take care not to steer away from the transference-love, or to repulse it or to make it distasteful to the patient; but he must just as resolutely withhold any response to it. He must keep firm hold of the transference-love, but treat it as something unreal, as a situation which has to be gone through in the treatment and traced back to its unconscious origins and which must assist in bringing all that is most deeply hidden in the patient's erotic life into her consciousness and therefore under her control. The more plainly the analyst lets it be seen that he is proof against every temptation, the more readily will he be able to extract from the situation its analytic content. The patient, whose sexual repression is of course not yet removed but merely pushed into the background, will then feel safe enough to allow all her preconditions for loving, all the phantasies springing from her sexual desires, all the detailed characteristics of her state of being in love, to come to light; and from these she will herself open the way to the infantile roots of her love.

There is, it is true, one class of women with whom this attempt to preserve the erotic transference for the purposes of analytic work without satisfying it will not succeed. These are women of elemental passionateness who tolerate no surrogates. They are children of nature who refuse to accept the psychical

[1] See the preceding paper [p. 150].

in place of the material, who, in the poet's words, are accessible only to 'the logic of soup, with dumplings for arguments'. With such people one has the choice between returning their love or else bringing down upon oneself the full enmity of a woman scorned. In neither case can one safeguard the interests of the treatment. One has to withdraw, unsuccessful; and all one can do is to turn the problem over in one's mind of how it is that a capacity for neurosis is joined with such an intractable need for love.

Many analysts will no doubt be agreed on the method by which other women, who are less violent in their love, can be gradually made to adopt the analytic attitude. What we do, above all, is to stress to the patient the unmistakable element of resistance in this 'love'. Genuine love, we say, would make her docile and intensify her readiness to solve the problems of her case, simply because the man she was in love with expected it of her. In such a case she would gladly choose the road to completion of the treatment, in order to acquire value in the doctor's eyes and to prepare herself for real life, where this feeling of love could find a proper place. Instead of this, we point out, she is showing a stubborn and rebellious spirit, she has thrown up all interest in her treatment, and clearly feels no respect for the doctor's well-founded convictions. She is thus bringing out a resistance under the guise of being in love with him; and in addition to this she has no compunction in placing him in a cleft stick. For if he refuses her love, as his duty and his understanding compel him to do, she can play the part of a woman scorned, and then withdraw from his therapeutic efforts out of revenge and resentment, exactly as she is now doing out of her ostensible love.

As a second argument against the genuineness of this love we advance the fact that it exhibits not a single new feature arising from the present situation, but is entirely composed of repetitions and copies of earlier reactions, including infantile ones. We undertake to prove this by a detailed analysis of the patient's behaviour in love.

If the necessary amount of patience is added to these arguments, it is usually possible to overcome the difficult situation and to continue the work with a love which has been moderated or transformed; the work then aims at uncovering the patient's infantile object-choice and the phantasies woven round it.

I should now like, however, to examine these arguments with a critical eye and to raise the question whether, in putting them forward to the patient, we are really telling the truth, or whether we are not resorting in our desperation to concealments and misrepresentations. In other words: can we truly say that the state of being in love which becomes manifest in analytic treatment is not a real one?

I think we have told the patient the truth, but not the whole truth regardless of the consequences. Of our two arguments the first is the stronger. The part played by resistance in transference-love is unquestionable and very considerable. Nevertheless the resistance did not, after all, *create* this love; it finds it ready to hand, makes use of it and aggravates its manifestations. Nor is the genuineness of the phenomenon disproved by the resistance. The second argument is far weaker. It is true that the love consists of new editions of old traits and that it repeats infantile reactions. But this is the essential character of every state of being in love. There is no such state which does not reproduce infantile prototypes. It is precisely from this infantile determination that it receives its compulsive character, verging as it does on the pathological. Transference-love has perhaps a degree less of freedom than the love which appears in ordinary life and is called normal; it displays its dependence on the infantile pattern more clearly and is less adaptable and capable of modification; but that is all, and not what is essential.

By what other signs can the genuineness of a love be recognized? By its efficacy, its serviceability in achieving the aim of love? In this respect transference-love seems to be second to none; one has the impression that one could obtain anything from it.

Let us sum up, therefore. We have no right to dispute that the state of being in love which makes its appearance in the course of analytic treatment has the character of a 'genuine' love. If it seems so lacking in normality, this is sufficiently explained by the fact that being in love in ordinary life, outside analysis, is also more similar to abnormal than to normal mental phenomena. Nevertheless, transference-love is characterized by certain features which ensure it a special position. In the first place, it is provoked by the analytic situation; secondly, it is greatly intensified by the resistance, which dominates the situation; and thirdly, it is lacking to a high

degree in a regard for reality, is less sensible, less concerned about consequences and more blind in its valuation of the loved person than we are prepared to admit in the case of normal love. We should not forget, however, that these departures from the norm constitute precisely what is essential about being in love.

As regards the analyst's line of action, it is the first of these three features of transference-love which is the decisive factor. He has evoked this love by instituting analytic treatment in order to cure the neurosis. For him, it is an unavoidable consequence of a medical situation, like the exposure of a patient's body or the imparting of a vital secret. It is therefore plain to him that he must not derive any personal advantage from it. The patient's willingness makes no difference; it merely throws the whole responsibility on the analyst himself. Indeed, as he must know, the patient had been prepared for no other mechanism of cure. After all the difficulties have been successfully overcome, she will often confess to having had an anticipatory phantasy at the time when she entered the treatment, to the effect that if she behaved well she would be rewarded at the end by the doctor's affection.

For the doctor, ethical motives unite with the technical ones to restrain him from giving the patient his love. The aim he has to keep in view is that this woman, whose capacity for love is impaired by infantile fixations, should gain free command over a function which is of such inestimable importance to her; that she should not, however, dissipate it in the treatment, but keep it ready for the time when, after her treatment, the demands of real life make themselves felt. He must not stage the scene of a dog-race in which the prize was to be a garland of sausages but which some humorist spoilt by throwing a single sausage on to the track. The result was, of course, that the dogs threw themselves upon it and forgot all about the race and about the garland that was luring them to victory in the far distance. I do not mean to say that it is always easy for the doctor to keep within the limits prescribed by ethics and technique. Those who are still youngish and not yet bound by strong ties may in particular find it a hard task. Sexual love is undoubtedly one of the chief things in life, and the union of mental and bodily satisfaction in the enjoyment of love is one of its culminating peaks. Apart from a few queer fanatics, all the world knows

this and conducts its life accordingly; science alone is too delicate to admit it. Again, when a woman sues for love, to reject and refuse is a distressing part for a man to play; and, in spite of neurosis and resistance, there is an incomparable fascination in a woman of high principles who confesses her passion. It is not a patient's crudely sensual desires which constitute the temptation. These are more likely to repel, and it will call for all the doctor's tolerance if he is to regard them as a natural phenomenon. It is rather, perhaps, a woman's subtler and aim-inhibited wishes which bring with them the danger of making a man forget his technique and his medical task for the sake of a fine experience.

And yet it is quite out of the question for the analyst to give way. However highly he may prize love he must prize even more highly the opportunity for helping his patient over a decisive stage in her life. She has to learn from him to overcome the pleasure principle, to give up a satisfaction which lies to hand but is socially not acceptable, in favour of a more distant one, which is perhaps altogether uncertain, but which is both psychologically and socially unimpeachable. To achieve this overcoming, she has to be led through the primal period of her mental development and on that path she has to acquire the extra piece of mental freedom which distinguishes conscious mental activity—in the systematic sense—from unconscious.[1]

The analytic psychotherapist thus has a threefold battle to wage—in his own mind against the forces which seek to drag him down from the analytic level; outside the analysis, against opponents who dispute the importance he attaches to the sexual instinctual forces and hinder him from making use of them in his scientific technique; and inside the analysis, against his patients, who at first behave like opponents but later on reveal the overvaluation of sexual life which dominates them, and who try to make him captive to their socially untamed passion.

The lay public, about whose attitude to psycho-analysis I spoke at the outset, will doubtless seize upon this discussion of transference-love as another opportunity for directing the attention of the world to the serious danger of this therapeutic method. The psycho-analyst knows that he is working with highly explosive forces and that he needs to proceed with as much caution and conscientiousness as a chemist. But when

[1] [This distinction is explained below, p. 266.]

have chemists ever been forbidden, because of the danger, from handling explosive substances, which are indispensable, on account of their effects? It is remarkable that psycho-analysis has to win for itself afresh all the liberties which have long since been accorded to other medical activities. I am certainly not in favour of giving up the harmless methods of treatment. For many cases they are sufficient, and, when all is said, human society has no more use for the *furor sanandi*[1] than for any other fanaticism. But to believe that the psychoneuroses are to be conquered by operating with harmless little remedies is grossly to under-estimate those disorders both as to their origin and their practical importance. No; in medical practice there will always be room for the '*ferrum*' and the '*ignis*' side by side with the '*medicina*';[2] and in the same way we shall never be able to do without a strictly regular, undiluted psycho-analysis which is not afraid to handle the most dangerous mental impulses and to obtain mastery over them for the benefit of the patient.

[1] ['Passion for curing people.']

[2] [An allusion to a saying attributed to Hippocrates: 'Those diseases which medicines do not cure, iron (the knife?) cures; those which iron cannot cure, fire cures; and those which fire cannot cure are to be reckoned wholly incurable.' *Aphorisms*, VII, 87 (*trans.* 1849).]

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Becoming an Individual: Technically Subversive Thoughts on the Role of the Analyst's Influence

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One of the most controversial issues in discussions of how psychoanalytic treatment "works" has been understanding the place and proper influence of the analyst's unique individuality on the process, and, in the terms framed in this paper, on the actual shaping of the patient's mind. This paper suggests that one reason this problem has endured is the absence of a framework for understanding how the analyst, *as a unique individual with an inextricable personal mind,* is key to the repair of the patient's impaired sense of agency and, as a consequence, the actual reconfiguration of the patient's mind. The paper argues that this personal process is not an unfortunate inevitability, but, like the developmental impact of the unique individuality of parents, represents an essential element, perhaps the core, of what enables real change and growth.

In 1954 Anna Freud had the following to say:

> With due respect for the necessary strictest handling and interpretation of the transference, I still feel that somewhere we should leave room for the realization that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other. I wonder whether our—at times complete—neglect of this side of the matter is not responsible for some of the hostile reactions which we get from our patients and which we are apt to ascribe only to "true transference." But these are *technically subversive thoughts* [italics added] and ought to be "handled with care." (p. 618)

MAKING SPACE FOR THE TRUE SELF: PERSONAL VERSUS ANALYTIC SUBJECTIVITY

Who are these "two real people?" What is their "real personal relationship?" Do they exist in some real space apart from the treatment relationship, which is not real or somehow less real? Or are

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they the treatment relationship? How shall we "leave room" for them? Room for what? And what exactly is so subversive that it must be "handled with care"?

As Anna Freud's more than half-century-old comment suggests, one of the most controversial, vexing, and enduring issues in the history of psychoanalysis has been the question of the place of the analyst's personal self, personal agency and influence as a real individual—as a *specific* subject, as opposed to what I call an *analytic* subject—on the treatment process, and specifically on the evolution and shaping of the patient's postanalytic self. In fact, beginning with Sigmund Freud's attempts to differentiate psychoanalysis from hypnosis and suggestion (Macalpine, 1950), the history of psychoanalysis is replete with theoretical and clinical efforts to describe and theorize how the analyst's unique individuality as a real person might be eliminated, or at least controlled and diminished enough, to be prevented from influencing or imprinting the patient.[1]

At the same time, in contrast to what was not supposed to emanate from the analyst—a personal voice as an individual—psychoanalysis had already developed, well before Winnicott (1963/1965) had formulated the concept of the "true self," a view that something "true" and authentic about the patient needed to emerge through psychoanalytic treatment. In an early discussion of the adolescent process, Freud (1905) presents an eloquent statement of what represents true, adult, individuality. In discussing the process of overcoming incestuous fantasies during adolescence, Freud suggests that

> one of the most significant, but also one of the most painful, *psychical achievements* of the pubertal period is completed: *detachment from parental authority*, a process that alone makes possible the opposition, which is so important for the progress of civilization, between the new generation and the old. At every stage in the course of development through which all human beings ought by rights to pass, a certain number are held back; so there are some who have never got over their parents authority and have withdrawn their affection from them either very incompletely or not at all [italics added]. (p. 227)

In this passage, Freud is not simply discussing adolescence, but in one of his most revolutionary manifestos, he asserts that the emergence into full adulthood is marked by the ability to take full possession of—or *agency* in (Pollock & Slavin, 1998)—one's own point of view, without the stifling, distorting, or contaminating effects of the voices of either parental or other received authority. Freud's position has an almost modern ring in his remarkably relational framing of the failure of some individuals to liberate their own voice in the course of complex developmental (parental) influences and of the necessity of finding a sense of personal agency to be fully an adult, or one's "true self." This sensibility—the effort to rid the patient of the hobbling voices of internalized authority including, in the end, that of the analyst (J. Slavin, 2007a)—forms a subtext of much of Freud's later technical thinking and recommendations.

It should be noted, for the discussion that follows, that in speaking of this detachment as a "psychical achievement" Freud is emphasizing the shaping of the *mind* of the individual, beyond casting off particular relational influences. For Freud, the issue in the treatment relationship was not the analyst's *behavior per se*, but the position and role of the analyst's mind in the process of influence on the patient's mind. Neutrality is not a behavioral prescription; it is about a mental position,

[1]Along with others (Hoffman, 1983; Mitchell, 1997; Renik, 1993), I have written elsewhere (J. Slavin, 1994, 2007a, 2007b) about some of the problematic aspects of these efforts to restrict the analyst's personal influence and his or her impact on the patient's personality.

as Anna Freud (1936, p. 28) noted, a position of equidistance in relation to internal conflict, designed, as the classical theorists hoped, to reduce or eliminate an external/analytic influence *on the patient's mind*.

Looked at from this perspective, the thrust of the "classical" understanding of the analyst's technical stance (J. Slavin, 1994)—the analyst's neutrality, abstinence, and minimalized participation—can be understood as aimed at trying to eliminate, or at least reduce, the analyst as a personal influence, a *specific* subject, on the process and on the patient's mind, thus enabling the patient's authentic self to emerge. In the context of this aim, a "transference cure" indicates a failure to protect the delicate emergence of the patient's true voice, resulting in the substitution of the voice of the original authority (the internalized parents') with the voice of another (the analyst's) in the patient's mind.[2]

The problem of the effect of the personal and the individual in the psychoanalytic process troubled Freud until the end of his life. In *Analysis Terminable and Interminable*, Freud (1937a) notes that, "among the factors which influence the prospects of analytic treatment and add to its difficulties in the same manner as resistances, must be reckoned the *individuality* [italics added] of the analyst" (p. 247). Yet, in one of his last technical papers Freud (1937b) returns to the problem of suggestion and the undue personal influence the analyst might have on the patient. He asserts—some might think quite astonishingly in the context his comment above and of reports about his actual way of working—that the

> danger of our leading the patient astray by suggestion, by persuading him to accept things which we ourselves believe but he ought not to, has certainly been enormously exaggerated. And the analyst would have had to behave very incorrectly before such a misfortune could overtake him; above all, he would have to blame himself with *not allowing his patients to have their say* [italics added]. I can assert without boasting that such an abuse of 'suggestion' has never occurred in my practice. (p. 262)

Although, as this passage suggests, Freud grew less concerned by the one-sided potential of personal influence,[3] the effort to eradicate the analyst's personal self was carried on and concretized in the way some versions of the classical treatment model developed through the better part of the 20th century, culminating in the concept of "the analyzing instrument" (Isakower, as cited in Arlow, 1979). In this concept, the analyst should be able to sufficiently remove himself or herself personally, so that his or her unconscious processes can be understood as a kind of scientific instrument from which, "the correct interpretation would appear automatically in the analyst's mind" (Arlow, 1979, p. 197), that can then be used to accomplish the psychoanalytic task. In other words, the analyst's analytic mind becomes completely distinguished from the personal mind which is ideally absent from the process. Even Arlow, known for his classical sensi-

[2]Whether Freud's thinking on this matter was related explicitly or implicitly to philosophical trends stemming from the Enlightenment about the nature of man—an idealization of a kind of tabula rasa, the emergence of the individual unsullied by the influences of the world—is beyond the scope of this discussion. However, it can be suggested that approaches in psychoanalysis that privilege the idea of an uninfluenced "true" or "real" self hark back to this conception.

[3]As is suggested in the previous quote, in his paper *Constructions in Analysis*, Freud (1937b) makes one of his most forthright statements of the necessary influence of the patient's mind on the process, including, as he says, "*allowing his patients to have their say.*" This fundamentally relational aspect of Freud's thinking about how analysis proceeds, the power he accords the patient's mind, is often overlooked in discussions of his understanding of the treatment process. A similar sensibility is also inherent in his understanding of the patient's associative process and its influence on the analyst's mind (Freud, 1912).

bility, calls this "an almost 'concretistic' view" (p. 197). Similarly, Freud's use of the surgeon analogy (1912) is often used to suggest some sort of idealized coldness or absence of personal feeling or involvement.[4]

In a similar vein, Macalpine (1950), writing in an illuminating and scholarly way about Freud's struggles with the issue of "suggestion" in analysis and his effort to differentiate it from hypnosis, makes clear that, while recognizing the powerful influence of the "analytic situation" on the patient, the analyst is never a *personal* influence. As Macalpine put it,

> The hypothesis has been presented here that both hypnosis and psychoanalysis exploit infantile situations which they *both create*. But *in hypnosis the transference is really and truly a mutual relationship existing between the hypnotist and the hypnotized*… in psychoanalytic therapy alone … the analyst has to resist all temptation to regress, he remains neutral, aloof, a spectator, and *he is never a coactor.* The analysand is induced to regress and to 'transfer' *alone* in response to the infantile analytic setting [italics added]. (p. 535)

At the same time, by the middle of the 20th century, a less positivist and objectivist understanding was beginning to be introduced—an understanding that included the impact of the analyst's presence as an *analytic subject*, although not quite yet as a *personal* subject. Loewald (1957/1980), using the exact wording as Macalpine, now frames the analyst as indeed a, "co-actor on the analytic stage" (p. 223), asserting that the analyst's role must necessarily include a direct influence (J. Slavin, 2007a), although it remains unclear how much Loewald meant that to encompass the analyst's full and true subjectivity. Nevertheless, efforts in theory construction continued to try to extract the specifically personal and idiographic from the process.

As Kleinian perspectives began to develop, it was understood—in a truly revolutionary contribution—that the patient's unconscious processes (i.e., the patient's *mind*) had a deep impact on the analyst's mind, providing the analyst with a new and exceptionally valuable lens from which to view and deeply understand the patient's psyche, through the analyst's own feelings and reactions, understood as projective identifications. Here, too, however, an assumption about the analyst as a kind of "analyzing instrument" is implicitly made. If the analyst is sufficiently analyzed and cognizant of his or her countertransference (no matter how difficult it might seem to be cognizant of what is essentially an unconscious process), the analyst's responses are to be understood as part of the process of projective identification and *not* a personal countertransference response (Heimann, 1950). In this perspective, most analysts could still agree on the goals—if not on the understanding—of the treatment process, that is, to provide the patient with the most "true" picture of themselves, unbiased by the contaminating and distorting effects of the analyst's personal influence.

Even as psychoanalysis shifted, in the work of Winnicott, for example, in the direction of a two-person psychology, with his understanding of the essential influence of a "holding environment" (Winnicott, 1960, p. 591) one can draw from Winnicott a sensibility that the "good enough"

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[4]I have discussed elsewhere (Slavin, 1994) that this interpretation may in fact be a misunderstanding of Freud's point. A close reading of the "surgeon analogy" text indicates that Freud was more preponderantly addressing the question of the analyst's ambition and narcissism in effecting a cure. "Therapeutic ambition," Freud says, "is the feeling that is most dangerous to a psychoanalyst" (p. 115), and he advocates that analysts should, in coping with their therapeutic zeal, model themselves after surgeons who carry out their craft as best they can and leave the outcome to God ("*Je le pansai, Dieu le guerit*.").

mother's (Winnicott, 1953, p. 94), or analyst's, personal influence and impact is uniquely undistorting and benign, so that the infant's or patient's "true self" can emerge.

As Winnicott (1971) framed it,

> What does the baby see when he or she looks at the mother's face? I am suggesting that, ordinarily, what the baby sees is himself or herself. In other words the mother is looking at the baby and what she looks like is related to what she sees there (p. 112). … This glimpse of the baby's and child's seeing the self in the mother's face, and afterwards in a mirror, gives a way of looking at analysis and at the psychotherapeutic task. Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings. It is a complex derivative of the face that reflects what is there to be seen. I like to think of my work this way, and to think that if I do this well enough the patient will find his or her own self, and will be able to exist and to feel real. Feeling real is more than existing; it is finding a way to exist as oneself, and to relate to objects as oneself, and to have a self into which to retreat for relaxation. (p. 117)

In one sense, Winnicott's work can be understood as an indirect contradiction of Freud's conclusion that the analyst must remove herself from the—as we call it today—intersubjective field, in order for the patient's true self to emerge. However, Winnicott's (1967, 1971) concepts of the holding environment and of potential space are not the same as authorizing the analyst's specifically personal subjectivity. In fact, one can suggest that Winnicott was able to use the idea of potential space, that is, of something not quite fully, externally real, in order to hedge his bets on the analyst's direct, personal impact and influence. Even the analyst's hate (Winnicott, 1949) is seen as representing a "good enough," so to speak, response to the patient's or to the child's behavior, or self, and is not simply a personal reaction. The hate, felt in appropriate moments, is seen as a necessary building block for the construction of the child's adequate personality.

The place in Winnicott where we see the specific, individual, and very personal impact of the mother on the child's mind, and in a corollary way, of the analyst, is in the influences that lead to the development the "false self." But a mother or analyst that engenders a false self is a *not* "good enough" mother or analyst.[5] In the passage from "Playing and Reality" quoted earlier, Winnicott (1971) differentiates the mother who gives back what the infant shows her with another version:

> I am asking that this which is naturally done well by mothers who are caring for their babies shall not be taken for granted. I can make my point by going straight over to the case of the baby whose mother reflects her own mood or, worse still, the rigidity of her own defences. In such a case what does the baby see? (p. 112)

Winnicott's reference to what is "naturally done" by mothers calls forth reverberations of what we also find in the classical view, the individual in his natural state where even the impact of another person does not sully the ability of the individual to "exist as oneself." What Winnicott seems to exclude from this formulation is the part that the mother or analyst must inevitably add to the exchange, not from disturbance as such, but simply because they are unique, different individuals—different from the baby, and different from what other mothers or analysts might see. What this unique mother or analyst sees is more than a reflection, and it returns to sculpt the child's, or patient's, psyche differently from what was sent out.

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[5]Thanks to Stephen Seligman (personal communication, November 27, 2009) for suggesting a closer look at the way Winnicott did and did not take account of the mother's subjectivity.

Self-psychological perspectives have also acknowledged the participation of the analyst as an inevitable factor in the analytic process, while holding, at least as an ideal, its own version of the "analyzing instrument," in this instance, the analyst's empathic attunement. While acknowledging that the analyst cannot be perfectly attuned, and that moments of misattunement and empathic failure can be opportunities for analytic progress, the ultimate goal is not the personal, *idiographically unique* participation of the analyst, but rather the recognition of the impact that that "failure" has had on the patient and on the process, in an effort to clarify and restore the empathic balance. Empathic failure represents the failure of the analyst to participate as an *analytic* subject, becoming instead, a *personal* subject. And it is the effects of that personal subjectivity that must then be repaired.

In a sense the self psychological position can be regarded as a mirror image or reciprocal of the Kleinian one: the failure is created not by the patient's projective identification, as in the Kleinian view, but from some, presumably countertransferential, moment of personal empathic failure on the part of the analyst (e.g., Atwood, Stolorow, & Trop, 1989). In neither perspective—the Kleinian or the self psychological—is the analyst's personal participation, however one understands its sources, viewed as not only inevitable but as essential, in and of itself, to analytic change and cure.

In what follows, I hope to make *exactly* this argument, about the essential nature of the analyst's specifically personal participation in the process of change. I mean participation not in terms of specific behaviors, relatedness, self-disclosures, or containment, but the encompassing way the analyst is a unique individual with a unique mind, and to the way this specific uniqueness of self and mind contributes to the reconstruction or reconfiguration of the patient's own emerging unique character and individuality. Rather than emerging a "true self" unsullied by the encounter with another, I argue that the patient's self and mind can grow and change only in the fertile soil (*soil* is in fact the root word of *sully*) of the complexity of another's mind and self, with *all* the potential *liabilities and benefits* that may be entailed in the process of intricate, intimate relating with another specific person.

PRESERVING THE RELATIONSHIP AS ANALYTIC

It was not until the advent of the American relational perspective (Aron, 1991; Benjamin, 1995; Davies, 1994; Ehrenberg, 1982; Fast, 1992a, 1992b; Greenberg, 1986; Greenberg & Mitchell, 1983; Hoffman, 1983; Mitchell, 1988, 1997; Renik, 1993; Seligman, 1999; J. Slavin, 1994; J. Slavin, Rahmani, & Pollock, 1998; M. Slavin, 1990) that the full subjectivity and participation of the analyst as an individual—as a personal, not just analytic, subject—was fully acknowledged as an *inevitable*—but not yet clearly a *necessary*—part of the analytic process.

Two points that often get obscured in discussions of the relational perspective is whether the analyst's personal participation is a facet of relationally oriented analysis, or of all analysis; and second, what "participation" actually means. "Participation," as used here, is not a behavioral term or injunction, but is an inherent, unavoidable characteristic of there being another, inevitably different, mind in the room (Benjamin, 1995, 2004). Indeed, one of the ways we may fail to fully grasp the core of a relational perspective is in thinking that the analyst is a full participant only when working from a "relational" point of view (however one defines it). This is a misunderstanding and concretization. The essence of the relational understanding is that the analyst is *inevitably*

a subject, participating with her unique mind in every aspect of the process within and between the parties, whether silently or verbally, consciously or unconsciously, in the way one dresses, decorates one's clinic, decides when and how to speak (or thinks one decides), including what analysts think their own and their patients' utterances and interactions may or may not mean. Whether one is working from a perspective—or behaving in the manner—of a classical, Kleinian, self psychological, or relational analyst, all these ways of *being* with the patient and within one's self are necessarily expressions of personal subjectivity, *of one's own mind*, whose origins and meaning reside (at least in the moment, whatever theory we may want to apply to them) in the unconscious and the unknown.

It is also a misunderstanding to think of a relational mode of working as necessarily more interactive than analysis understood from other perspectives.[6] What is "relational" about an analytic process is not the level of interaction, but how we understand the nature of the minds we believe analyst and patient have and how they are affecting one another. A relational mode of working is one that takes into account the view that the mind of both analyst and patient are continually constructed and organized relationally (Benjamin, 1995, 2004; Fast, 1992a, 1992b, 1998, 1999, 2006, personal communication, 1990's) in a process that cannot be avoided no matter how individuals may conduct themselves.

In this sense, personal participation is as inevitable and ubiquitous as is our unconscious process, for all analysts and in all analytic perspectives. Indeed, it is the combination of these two factors—our *personal participation and our unconscious process*—occurring at one and the same time, most of the time, that makes our efforts in "preserving the relationship as analytic," as Mitchell (1997, p. 228) put it, so incredibly challenging. *How in the world can we insure that our inevitable personal participation, about which we will be largely unaware, accomplishes a serious analytic purpose?* Yet, as I hope to illustrate, these same two factors—our unconscious processes and our inevitable personal participation and subjectivity, the very two aspects of our individuality as persons about which we have the least control and awareness—also *contain all of the enormous potential and promise of psychoanalytic work.*

A paper published by Franco Borgogno (2004) of his work with his patient M provides a very clear illustration about not simply the inevitable, but the essential nature of the analyst's personal participation. As Borgogno describes his patient, M was a woman who felt, at best, invisible to her parents; she was a child they wished not to have, and wanted to abort and discard. M's inability to feel wanted by her parents, to feel responded to, to feel like she could affect them as a person was, as Borgogno describes it, and as many analysts experience with their own patients, profound. Instead, in Borgogno's evocative words, M was, "an orphan … of parental transformative reverie and representation" (p. 480) which led to a life-debilitating and paralyzing feeling of internal emptiness, deadness, and suffocation. The patient's image in a first dream of someone committing hari-kari while in a cloister provides a picture of the patient's inner life at the beginning of the treatment.

What transpired in this treatment, as Borgogno experiences and narrates it, was the patient's profound impact on him and on his psyche, in a way that is known to many analysts, especially dramatically with certain patients during the course of one's career. Although most analysts are familiar with this kind of experience, the ubiquity and power of the way patient's touch us and "get

[6]The question of the "interactive" implications of the views developed here are addressed later.

into" us has not always been as clearly emphasized in analytic writing as in the private conversations analysts have, perhaps because we have had no clear way to see this impact as an essential ingredient of analytic work, indeed, if you will, analytic technique.[7] In this way, M gets into Borgogno, deeply, into his dreams, into his feelings, into his deepest self in a way that convinces him that he is experiencing something quite like hers. She was clearly *not* an orphan of *his* "transformative reverie and representation." Moreover, Borgogno tells us, it is the patient's capacity to sense *how* he is experiencing all of her most profound and painful feelings, that begins to enable her to return to life and to feel that she exists.

Of course, this brief summary does not do justice to what occurred in this deep and complex treatment. While there may be many ways for analysts of different persuasions to account for what happened there, I became intrigued by Borgogno's emphasis on the necessity of the patient witnessing how the analyst is processing and internalizing the patient's experience. But it was not clear to me that his emphasis on the necessity of this experience was fully explicated in his text. More strikingly, the title of his paper includes the phrase, "on the patient becoming an individual." While the main body of his title ("The importance of the analyst's personal response to a deprived patient") is discussed directly, that specific phrase, becoming an individual, is never further addressed by him. What might Borgogno mean by the patient "becoming an individual," or rather, how might we come to understand it?

In several papers, I and others (Benjamin, 1995; Gentile, 1998, 2001; Pollock & Slavin, 1998; J. Slavin, 2002; J. Slavin & Pollock, 1997) have developed the conception of personal agency in a psychoanalytic context, how the experience of agency emerges, how it may be stunted and suffocated in developmental experience, and how personal agency may be restored in treatment. By a sense of agency, I refer (Pollock & Slavin, 1998) to the *internal*, ongoing experience that one matters in the relational world, the belief that one has the possibility of having an impact on others. The psychic experience of agency develops in the infant's relationship with earliest caregivers, not simply through the ability of the caregiver to provide "recognition" to the child—that is the caretaker's agency—but rather, in the many moments throughout the course of development from earliest life through Oedipal, and post-oedipal (Davies, 2003) phases, as the infant (and later the child, and even the adult) understands, in repeated iterations, that recognition is not simply being provided by the other but is actually being "won," from them, extracted from them, by the infant's or child's or individual's own actions and existence (Benjamin, 1995). *It is this sense of knowing, seeing, and repeating one's impact on another that makes one feel that one exists*. As Borgogno's patient M movingly says, "If you discover that you have an effect on other people, you feel real; you feel that you exist: therefore, others also exist for you and are real. This is what you give me" (p. 47).

A cohesive sense of personal agency can fail to develop, or be crushed in many ways, in sexual trauma, for example, where the child's mind and motives are toyed with and she is unable to determine who wanted what, and who made what happen (Slavin & Pollock, 1997). But agency can also be twisted, suffocated, and destroyed more insidiously, by the failure of the parents to be able to see and recognize the child as an individual in their own right, apart from the parents' own mental scheme of who the child is or should be. In such circumstances the individual's lack of meaning

[7]Luz-Alterman (2004) provided some especially striking examples and a compelling relational formulation of the powerful impact of patients on the mind of the analyst.

anything in the world for themselves, or, beyond the false self (Winnicott, 1963), of even knowing who one truly is, may be the basis for a haunting feeling of lifeless existence.

Looked at from the point of view of agency, Borgogno's insistence on the analyst experiencing the patient as he feels he experiences her, as if he "caught" her illness, and on the necessity of the patient witnessing this process, takes on greater clarity. What happened between M and Borgogno was a reengagement of the stunted and suffocated aspects of M's sense of agency. She was able to touch her analyst deeply, as many patients manage to do, and see that she had an impact. Her desire affected him visibly. I think for this reason Borgogno quite rightly emphasizes the essential element of the patient's recognition of what is happening to the analyst. She can see she means something very real to him.

SUBVERSIVE THOUGHTS ON THERAPEUTIC ACTION: BECOMING AN INDIVIDUAL

Were we to stop here, we would find the presentation of a vivid example of the way agency is destroyed during development and how it may be reconstructed and healed in the complex, often turmoil filled, and ultimately very real relationship (J. Slavin, Rahmani, & Pollock, 1998) with a willing, malleable, emotionally responsive, and, of necessity, strong analyst. While worth re-emphasizing, it is a known perspective. But, as I noted, Borgogno hints at another element, the patient's "becoming an individual."

What is the meaning of this enigmatic phrase? Might it add anything to what we have already discussed in terms of the destruction and the repair of the patient's agency? Although Borgogno does not explicitly follow up on this question, I believe that it brings to light a critical facet of individual development and the true nature of psychoanalytic treatment. Addressing this issue requires us to return to the question of the *personal, individual* role of the analyst in the treatment process.

In fact, when we examine the re-creation of the experience of agency in analytic treatment we can easily elide the question, *Who* is the specific individual with whom the patient is experiencing some impact and some reciprocal participation? This specific individuality has historically been the very thing to be avoided in psychoanalysis. But the analyst's responsiveness to the patient's agency is not simply as a generic agent, or as I called it earlier, an *analytic* subject, but rather as a *particular person*, an individual with his or her own personality distinct from that of any other analyst. The analyst will respond, but will respond in *his* or *her own* way. As we saw, some of our theories and points of view have tried to contain, narrow, and de-individualize the analyst's response. As I discussed earlier, and as Renik (1993, 2006) has emphasized, one of the inescapable points of the relational perspective is that this effort to restrict the analyst's responsiveness and extract the unique individual qualities from it, are as bound to fail as is any effort to eradicate the analyst's unconscious processes from affecting his or her way of responding. How does one delete an unconsciousness that the analyst is not aware of? Can we assume that our implicit, uniquely characteristic ways we have of being people are not being perceived by, and affecting, the patient? And, to the point of this paper, are these qualities of the *unique personal mind* of the analyst simply the detritus of a messy process to be avoided and swept aside, or might they be the critical factors that are the foundation for the patient's most profound reconfiguration of himself?

I believe that this is what is truly called to our attention in the phrase, "becoming an individual," and in Borgogno's emphasis that the patient must be able to experience the particular analyst's way of internalizing and experiencing the patient's process and feelings. In order to *become an individual*, the patient needs the unique, idiographic, personal responsiveness of the analyst, not simply to resurrect or repair a stifled sense of personal agency, but to help *re-create, or even create for the first time*, the particular, highly individual configuration and nuanced qualities that will become important facets of his or her own postanalytic mind and personality, much as we might think that the particular mind and personality of every infant and child emerges out of the engagement with specific *individual* parents, rather than with generic parenting figures. Although psychoanalysts have for decades wanted to eschew their personal influence on the process, and on the outcome of the patient's personality, I believe that it is *just this very personal influence*, of the analyst as an individual, but working *as an analyst*, that is essential for the differentiation and definition of the patient's own mind and self.

Moreover, this personal influence does not occur simply in response to the patient's agency, as vital as that is. I believe that analysts inevitably bring their own desire, and the desire to have their own personality and individuality to be known, even if consciously unacknowledged or denied, to the encounter with the patient. This very specific individuality that the patient comes to know, indeed as M. Slavin and Kriegman (1998) suggested, insists on knowing—and that ultimately the analyst allows to become known—is an essential aspect of what the patient needs and uses to change and reconfigure herself, in effect using the analyst to chisel and sculpt the shape of her future self.

One patient, N, who had an uncanny sense of the process, articulated directly her need to know that I had, and was in possession of, my own desire and my own agenda in order to feel she was in a relationship that could really help her. Any effort I might make to try, in the language we had developed, to simply be on "her page," was for her, quite rightly, inauthentic. As N put it in an e-mail barely a month into analysis,

> It seemed to me that in order for you to be on my page, something of me should be on your page as well. Not in a sense of having me in the service of your needs, but in the sense of making you feel that it's important for YOU to help me. … That may not be having a specific agenda, but you must have something.

Some weeks after, N wrote,

> So in the last session you told me that here was something very interesting, "theoretically intriguing," as it was related to issues of countertransference and maybe other things. You sounded quite excited, and I was excited as well, saying: "I am happy to be theoretically intriguing." And I really meant that. Somebody else could have been upset when hearing this – if she needs her therapist to be with her "here and now" and not on a higher theoretical, academic level, she may not be able to understand. But I was thrilled. I felt that on the level of our relationship you did exactly what I asked for: you got me on your page and you have let me know about that. I know that "your page" contains also theoretical and generic questions in therapy, and by hearing what you said I knew that I became relevant for you not only as a patient you want to cure, but as someone in whom you may find special personal interest—it may be helpful for you and your interests in a way. I don't know if I'm saying something new here but I think it needs emphasis: I am saying that I need you, as my therapist, to be personally interested in me on a level that might serve your personal interests. I think this is counterintuitive to the common sense when thinking about treating people, but I am sure it is absolutely real in terms of actual relationships

> "outside" therapy. And maybe by this I was saying more: I don't want this relationship to be artificial, clinical, ad-hoc, which is created just for the sake of the clinical issues, I want it to be real, normal, a bond between two people who really, genuinely, want to have something together.

Counterintuitive indeed. Even technically subversive. N stated that what she needed from me was a quality that is also "absolutely real in terms of actual relationships 'outside' therapy." I believe she is right about that. From infancy on others need and use us for themselves, for their own interests. Moreover, and vital to our understanding, in the moment by moment, subtle and overt interactions we have with others thousands of time a day from infancy on, we make use of the way others need and use us, to find, and to define, ourselves. As we discover how others need and use us *for their own interests, we discover who we are* as individuals, and who we are and can be to them. In our work we use the way our patient's use us to sculpt and define ourselves as therapists.

Clearly, as analysts who hear relentlessly of the dismal and destructive impact of others' interests on our patients, of how they have been *misused*, we are rightly aware of the dangers of another person's desires and needs, of, "the abuse of suggestion," as Freud put it. But in our concern about the potential for abuse, have we also obscured the constructive and utterly necessary influence of another, including the other's personal interest and desire, indeed their desire to use another, in creating, defining and—in analytic treatment—repairing oneself?[8]

I wonder if we have become wary of the destructive potential of object usage (Winnicott, 1969), while overlooking its essential and constructive role in the course of development. Perhaps Winnicott is suggesting as much when he wrote

> It is important to note that it is not only that the subject destroys the object because the object is placed outside the area of omnipotent control. It is equally significant to state this the other way round and to say that it is the destruction of the object that places the object outside the area of the subject's omnipotent control. In these ways the object develops its own autonomy and life, and (if it survives) contributes-in to the subject, *according to its own properties* [italics added]. (p. 713)

That the object contributes to the subject, "according to its own properties," implies the object's independent existence with its own agenda, its own interests, and its own desire to use the subject. And as Winnicott suggests, this will contribute to the subject's growth.

The question of the analyst's personal influence has, of course, been discussed before. Renik (1993) noted that despite our best efforts, analysts cannot escape the question of their personal impact on the process, on the patient, and on the outcome. Mitchell (1997) put it even more starkly in the terms I am emphasizing here, the impact of one unique mind on another:

> In recent decades, there has been increasingly greater emphasis on the ways in which the analyst is internalized in lasting identifications. We are … most comfortable speaking of these identifications as generic functions, like the analyst's "observing ego," analyzing function, and so on. But more and more we are able to *acknowledge to ourselves and to each other that the specific person* of the analyst, *in his or her unique subjectivity*, becomes *a lasting presence* in the postanalytic world of the analysand. [italics added] (p. 230)

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[8]In previous writing (J. Slavin et al., 1998) colleagues and I have discussed the question of the potential danger of the analyst's real person and real influence on the analytic process and on the patient and how concerns about this have affected our theory and our practice for generations. In that earlier work, and now, I argue that the deleterious effects of a narrowed and constricted (unreal) analytic responsiveness may represent a greater harm—as well as an impossible task—than would be accepting, knowing and welcoming the analyst's inevitable realness and impact.

Yet one of the difficulties we have had in acknowledging more overtly the role of the analyst's impact, and the "lasting presence" of this impact, arises in connection with the danger inherent in stepping into a view of analytic change *as residing in the personal, and not simply in the process itself*, a danger that also occupied Mitchell. Earlier, in the same work just quoted, Mitchell (1997) addresses this danger:

> One of the major features of the analyst's role is his or her function in preserving the relationship *as analytic* and conducting and protecting the inquiry. While the analysand's role entails giving oneself over to the experience of the analytic process, the analyst, in addition to … experiential self-monitoring, must also pay attention to holding and protecting the process … analogous to that of the "designated driver" at a party. … Someone has to be mindful of the bigger picture, and it is precisely that mindfulness that allows a surrender to the experience for the *other* [italics added] participants. (p. 228)

I think in this pair of observations we get a look at the struggle that engages not only Mitchell, but our field. Mitchell acknowledged, however wistfully, the inevitable impact of the analyst's subjectivity on the patient's mind. But he was not fully comfortable with it and he wanted to limit it, thus the "designated driver," a kind of relationally framed neutrality.

Like Mitchell, we may come to feel that despite our best efforts to erase or restrict our personal influence, we will inevitably fail to do so. We may even reconcile ourselves to the ineluctable outcome that, "our hands are not clean," as Hoffman (1996, p. 109) put it, albeit with some sense of resignation at our inability to prevent our ultimate failure to be a true analyzing instrument.

But I wonder if what has held us back from a more open embrace of this side of our work is the absence of a comprehensive formulation and theory that might provide a convincing understanding of how the personal is fundamental to the process, that demonstrates that an analyst's real and personal influence is essential. In contrast, we have, since Freud, been very aware of the potential destructiveness of the personal. I am endeavoring to formulate at least an initial view of not simply the inevitable, but the *essential* therapeutic value of the analyst's personal self and mind, including, as N reminds us, the analyst's own real interests.

The shift I am suggesting from an "acceptance" of the inevitability of personal influence, to a genuinely deep embrace of its *necessity and even primacy* in the process of analytic change is a question of more than theoretical interest. How and what we think, our theory and framework, subtly but deeply affects what we do clinically in unconscious as well as conscious ways. An analyst who truly understands and welcomes that she will be giving a real part of her mind, as a vital ingredient to the shaping of her patient's psyche, will carry that attitude with her into every implicit and nuanced way that she is with her patient. She will carry this understanding, even as, like any good analyst, she maintains her professional objectivity and hopes to enable her patients to find the freedom to become themselves without imposing some preconceived agenda on them. Indeed, she may not only be more open to but also more mindful of encountering aspects of her influence in her patient's change and growth.

This revised view of the real influence of the analyst's personality does not change how the analyst understands the task as we ordinarily think of it: to listen, to follow one's own and the patient's associations and affects,[9] and to communicate what one thinks one understands about the

[9]It is rarely noted that the classical process of listening to patients' associations is not simply a way, derived from positivism, of observing the mind and affect of another, as if outside. It also represents an ingenious mode of attuning oneself to, and participating with some potentially greater awareness in, the ebb and flow of thought and affect engendered by the minds of two people.

patient's life and struggles when it seems right to do so. Nevertheless, this working analyst will be a very different analyst from one who simply "accepts" a certain fated inevitability about the impingement of her personality on the process, and, of course, surely different from one who deliberately tries to withhold or contain it.

It is important to stress that the essential point in this discussion is not whether the analyst is being more of an analytic subject or a personal subject. That is an impossible distinction that has distracted psychoanalysis for 100 years for no real gain. These facets can never be weighted in one direction or another, as if one could choose to be more an analytic subject in some instances and more a personal one in another. *These are not techniques, nor are they poles on a continuum*; they are inextricable. That is why efforts to construct an isolated analytic subjectivity were bound to fail. How the analyst is doing an analysis is a reflection of her own mind, a particular mind, her personal absorption of her professional learning, affected always by her personal unconscious process and the patient with whom she is sitting.

Yet it should also be clear that this perspective in no way suggests that there is no such thing as analysis apart from individual behavior or that, in the phrase often hurled at relational analysts, "anything goes." That would be akin to saying there is no such thing as parenting aside from the individual interaction between an older person and a younger. Human beings know very well what parenting is apart from each individual parent, and while we don't necessarily formally train for it, we spend our entire lives observing it and learning it. Our analytic conversations in institutes, supervisions, conferences, and scholarly publications are much the same process, the effort to help us frame in our minds what is entailed in being a good analyst, even what techniques might be helpful, the same way parents learn helpful techniques to engage, soothe, teach, and enhance the growth of their children. Apart from some extreme behaviorists, no one would ever think that we should, let alone could, extract the personal from parenting. We even think it is essential. I am arguing that in analysis this uniqueness of the other is no less essential, since growth and change rely on the same processes of interaction and responsiveness, that is, the use of another's mind to sculpt and shape one's own. As the infant organizes and reorganizes around the unique, irreproducible responsiveness of the mother who is being a mother, one who takes it seriously and is doing her best to privilege her child's interests, so the patient will, with the analyst's skilled, professional help, begin to use the analyst's responsiveness to reorganize the nature of his own post-analytic self. In this sense, the engagement with a *particular* analyst will affect the configuration of the individuality of his patient's mind in some ways no less than a parent. Indeed, if we did not believe that our impact on our patients could be in some fundamental way comparable to that of parents, our hope for, and belief in change, truly basic change, would be devoid of substance.

FINDING THE ANALYST'S MIND

In this discussion, I have endeavored to distinguish the effect of the analyst's mind on the ability of the patient to reshape his own fundamental psychic organization, from the question of the interpersonal interaction they may have. These two dimensions, the personal mind of the analyst and the actual interaction, are often conflated, both by those who may view relational psychoanalysis as a superficial process providing some form of interpersonal support and in some of our theoretical discussions. Thus, any discussion of the role of the analyst's personal mind would be incom-

plete without addressing the question of the implication of the perspective I am developing for the actual behavior of the analyst in treatment.

In my experience as well as in that of colleagues, patients—especially, but not only, those who have been in less than successful prior treatments—often *crave* the accessibility and authenticity of the analyst. In my own experience they are surprised and immensely relieved by finding an analyst behaving in a nonstilted way, asking questions, interacting naturally, responding to questions without artifice, musing with them about the meaning of what they are saying, from the beginning. What is this relief about? What has the patient found? Has it anything to do with serious psychoanalytic work and the issues about the analyst's mind that I have argued so far?

Some years before Anna Freud wrote about the two real people in the room in a real relationship, Otto Fenichel (1941), arguably the spokesperson of his time for a classical view of psychopathology and classical technique, wrote in an intriguing way, that

> fear of the countertransference may lead an analyst to the suppression of all human freedom in his own reactions to patients. … I have often been surprised at the frequency with which I hear from patients who had previously been in analysis with another analyst, that they were astonished at my "freedom" and "naturalness" in the analysis. They had believed that an analyst is a special creation and is not permitted to be human! *Just the opposite impression should prevail. The patient should always be able to rely upon the humanness of the analyst* [italics added]. (p. 74)[10]

What might Fenichel have meant by the analyst's "humanness"? And why should the patient always be able to rely on it? Is this about establishing rapport, safety, an alliance? Surely. But is there something more? This is the corollary question to why many patients crave this humanness, or as I put it earlier, our accessibility. Perhaps we should also ask what is it that creates a feeling of safety and rapport in the analyst's accessibility and authenticity?

In the context of the framework I have proposed, I wonder if our patients don't implicitly "know" something about what they need to find that an analyst's humanness and accessibility suggests to them: That is, that they will have real access to the analyst's mind, and that there could be a hope in this relationship of an end to the obfuscations and covert agendas that have marked their internalized relational experience. If the patient needs to be able to find and use the mind of the analyst to reconfigure the shape of their own psyche, might the need patients have for authenticity, for accessibility, represent safety on a deeper level, on a level which offers the hope that they will be able to access something real, individual, with its own knowable shape and form that can help them reshape themselves? Might we say, then, that real, nonstilted interaction that unfolds in an ordinary way, within a professional setting, might be the first signal the patient has that here is an opportunity for change that had not been found before? Framed in this way, perhaps the idea of "interaction" marked by a level of genuine accessibility—that fits the particular personality of the analyst—might be considered fundamental building blocks of real psychoanalytic technique. My aim here is not to prescribe "more interaction" but to understand something about what patients over decades have longed for, what analysts over decades have struggled about providing—access to the analyst's mind—and some of the reasons why this struggle has persisted.

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[10]Similar views were expressed in the next generation of venerated classical contributors. Elizabeth Zetzel (1958/1970) noted that "otherwise warm and friendly psychiatrists often adopt in the analytic situation an attitude of silence and uncompromising rigidity. … It may be the analyst's conviction that any real relationship between patient and himself should be rigorously avoided. … It is, however, my increasing conviction … that serious problems in subsequent transference analysis may frequently be attributed to failure to achieve a secure therapeutic alliance" (pp. 204–205).

TWO REAL PEOPLE

The view I am suggesting fully authorizes the analyst's specifically personal subjectivity and individuality as it may occur explicitly, and more commonly unconsciously and implicitly, not as something we must concede as inevitable and unavoidable, but as, first and foremost, the fundamental mode of therapeutic action. The analyst's unique, fingerprinted, so to speak, mind is the whetstone on which the patient, reviving the core issues of his identity within the gift of a human capacity for transference (J. Slavin, 1994; M. Slavin & Kriegman, 1992) resculpts and reconfigures herself.

I began with Anna Freud's striking comment about the "two real people" in the room. In this discussion I have attempted to place this "realness" in the framework of a theory of therapeutic action that I hope will enable analysts to take more full possession of their individuality as essential, foundational, elements of their professional work. Guntrip (1975) perhaps said it best:

> To find a good parent at the start is the basis of psychic health. In its lack, to find a genuine "good object" in one's analyst is both a transference experience and a real life experience. In analysis as in real life, all relationships have a subtly dual nature. All through life we take into ourselves both good and bad figures who either strengthen or disturb us, and it is the same in psychoanalytic therapy: it is the meeting and interacting of *two real people* [italics added] in all its complex possibilities. (p. 156)

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