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## What is Psychoanalysis?

Psychoanalysis can have a scientific foundation, and does have a future, even if it is a procedure in which the investigator has an indissoluble influence on what is being investigated, and the possibility of replication is deeply compromised by the uniqueness of the relationship. Psychoanalytic notions do not readily lend themselves to empirical validation. Yet it has been increasingly recognized in contemporary philosophy of science that these problems are general to all scientific inquiry and they represent the limitations of all science. The fact that it is very difficult to validate psychoanalytic hypotheses is not restricted only to psychoanalysis as a science; witness the plethora of contemporary theories and arguments in such traditional sciences as physics and astrophysics about quantum theory, about the so-called “cosmological constant” and whether it is necessary to postulate an inflationary phase in the origin of the universe, and the curious difficulty of locating proton decay, determining the mass of neutrinos, and finding gravitational waves predicted by the various theories but so far not possible to convincingly demonstrate empirically. Some very elaborate hypotheses such as “string theory” have never produced a single testable prediction. The whole conception of science in the twentieth century has shifted, but it does not follow from this that the data of psychoanalysis any more than the data of any other field, are nothing but the current product of an interaction or a dialogue between patient and analyst. This is true in spite of the current fashion as expressed, for example, by the popularity of Bakhtin’s (Emerson 1997) postmodern concepts of dialogue, polyphony, and unfinalizability. This so-called postmodern stance may or may not be valid but it is far from generally accepted and the whole current fashion of postmodernism and hermeneutics remains very poorly defined and highly polemical.

Psychoanalytic theories are not idolized today as they once were, because we now know that all theories tend to filter awareness and promote counter-transference. On the other hand we need theories, for in any science, as Kuhn (1962) in his famous work explained it, there has to be a “stable paradigmatic corpus of notions,” a group of core defining ideas. Progress in science involves departures from the prevailing paradigm, but just as science is dead without innovations, so it is lost without its traditions and fundamental body of acquired knowledge. For us, this has been and should continue to be provided by the work of Freud and the psychoanalytic pioneers as summarized in Fenichel’s (1945) classic textbook and brought up to date by others. Much of the recent psychoanalytic literature, however, attempts not to modify and correct Freud’s paradigm as of course it ought to be done on the basis of new research findings, but to replace it entirely in the name of either making psychoanalysis more of a traditional science or of making it a relationship therapy or a purely hermeneutic exercise. This is a major mistake and, contrary to current fashion, we should retain Freud’s basic ideas as our central paradigm and starting point. I strongly disagree with the claim that we are now close to solving the so-called “hard problem” challenge of the mind-brain problem, the problem of how to get from neuronal firings to the qualia of consciousness. This is exactly what stymied Freud, causing him to abandon his “Project for a Scientific Psychology” and develop his metapsychology.

The only way I know of to establish scientific knowledge is by consensual validation from a series of investigators. Indeed, there has been a serious effort by prominent psychoanalysts, especially in last twenty years to establish some areas of confluence. For example, Gabbard (1995) published an important paper delineating the gradual migration in our field away from extreme positions and toward some generally accepted principles, and Wallerstein’s (1988) seminal paper “One Psychoanalysis or Many?” was a central topic of discussion at the 1989 International Psychoanalytical Congress. It is easy to criticize psychoanalytic institutions and bureaucracies and many authors (e.g., Gedo 1997) have done so; nobody would disagree that such organizations should fear dogma more than freedom of inquiry, but it is very difficult, human narcissism and group psychology being what it is, to keep such organizations from becoming a conservative force. At the same time, there is a wealth of clinical knowledge and useful theoretical ideas to be found in Freud’s pellucid writings that are of foundational value even today. When Kohut was asked what to read after one reads Freud he replied, “Read Freud again.”

Psychoanalysis, although containing a significant hermeneutic aspect, is primarily a clinical science. Also, as originally pointed out by the philosopher Paul Ricoeur (1970), it is a new form of investigation, one that combines both hermeneutics and empirical study. Furthermore, it is increasingly a medical science, for we are in the era of great advances in psychopharmacology and it

is no longer unusual these days during psychoanalytic treatment that psychopharmacological medications are prescribed. Both the psychic effect of such prescriptions as well as the physiological effects, including the effects of combining psychopharmacologic agents with other particular medications the patient may be taking, have to be considered and evaluated by the analyst or, in situations where the analyst is not a physician, by a consultant psychiatrist. Prescribing necessary medication is not so different from Freud's feeding of the "Rat-Man" or collecting money for the "Wolf-Man," and it carries the same complications for the transference and potential for countertransference enactment. But it is also a countertransference enactment to withhold necessary medication from a patient, entailing needless suffering. Also, the variety of physical symptoms and problems that arise during the course of a long psychoanalysis, in addition to the already ongoing medical problems of those patients who enter psychoanalysis with a psychosomatic disorder, will require experienced medical judgment.

## HERMENEUTICS

Ricoeur, in his famous seminal work, *Freud and Philosophy* (1970), said there are two kinds of hermeneutics. The first of these he labels the "hermeneutics of suspicion," represented by the work of Freud, Marx, and Nietzsche, to some extent Feuerbach, and, I would add, Foucault. Their task is demystification and a reduction of "illusions." A crisis of the philosophy of the subject is involved here; these authors point to the lie of consciousness and to consciousness as a lie. For Freud, consciousness expresses the unconscious and sexuality; for Marx, the conscious is formed by economics. In 1888, Nietzsche's last good year, Freud was thirty-two-years-old and deeply immersed in psychoanalytic work on hysteria; he had not yet undertaken his self-analysis. In that year Nietzsche wrote that all philosophy is interpretation, a tearing-off of masks.

Freud built a one-person or solipsistic metapsychological model, his "mental apparatus," out of a two-person dialogue that was dyadic and non-solipsistic. Ricoeur's discussion of Freud's work places great emphasis on dreams as the key to the psychoanalytic focus on the relationship of desire to language. The text of a dream is the manifest dream; owing to repression it is a coded message. The latent dream Ricoeur calls the "primitive speech of desire." Freud used hermeneutics to get from the text of the dream to the primitive speech of desire and the same process is used for decoding neurotic symptoms.

Viewed in this fashion, Freud's crucial question is: "How does desire achieve speech?" This is found as early as in Freud's theory of aphasia. Freud's

explanation of aphasia denies the standard brain location theory (Broca's area, for example) and instead conceives of aphasia as a nonlocalized neurological situation in which speech is cut off from the concepts signified by the words. This leads to Freud's (1914a) later use of the connection or lack of connection of "thing-presentations" with "word-presentations" in his theories of neurosis and psychosis. But in Freud there is a contradiction, for in Freud's metapsychology the human remains a "thing," a "psychic apparatus," and this metapsychology is an attempt at a scientific set of quasi-neurological explanations.

The oscillation between a humanistic and a mechanistic view of humans is a well-known hidden tension in Freud's thought (Holt 1973). Even Freud's wish to decode symptoms and dreams implies a value system in its dedicated pursuit of meaning, coherence, and clarity. Freud begins with a simple natural-sciences hydraulic model and ends with a mythology, the "battle of the giants" (Freud 1930, 122), Eros and the death instinct.<sup>1</sup> But when Freud emphasizes only the dismal, neurotic, regressive, and projective aspects of art and religion, he is actually projecting his own pessimism, his own blinders that allow him to see only the negative aspects. Even psychoanalytic code-breaking, even deciphering, even hermeneutics are permeated by one's own fundamental life attitudes. There is no such thing as a study of truth that does not involve the person doing the study. One's own life attitudes are hidden premises in whatever study one makes.

Freud's original idea of psychoanalysis contains two aspects. The first of these involves explanations through the use of forces, or energetics. These are the so-called "economic explanations" that are made, involving dynamic forces playing against each other. The second presents an exegesis of the apparent or manifest through the latent, the classical hermeneutic approach. But psychoanalysis always has to incorporate energetics into hermeneutics in order to make a psychoanalytic interpretation. This is because the distortions that take place, when one goes from the latent to the manifest, occur for a reason; there is a force at work that must be understood to explain why these particular sets of transformations take place. Because of this force, explanations must involve energetics, dynamics, and so on. The earliest conceptions of psychoanalysis, as in *The Interpretation of Dreams*, contain explanations using energetics and explanations using hermeneutics.

The methodological incorporation of hermeneutics and energetics was Freud's crucial epistemological discovery. It represents a new form of investigation, an alternative to investigating the data of clinical psychiatry and the narratives constituting psychoanalysis and psychoanalytic psychotherapy by either standard natural sciences empirical statistical study or by speculative subjective intuitions. The argument that hermeneutics combined with energetics begins a relevant and autonomous intellectual discipline with its own methodology offers an important message for any mental health professional

who feels there has to be an alternative in our work to either the inhumane mechanism of hard empirical science on the one hand or a purely speculative philosophy on the other.

But the problem with hermeneutics is that it does not provide any body of convincingly testable propositions. This runs the risk of it being an arcane source of wisdom that generates little evidence that we may proceed to verify. Recognizing this objection, Ricoeur (1977) tried to answer it with his concept that the analytic experience is equivalent to what the epistemology of logical empiricism calls observable measurable data. For Ricoeur, in psychoanalysis there are no facts, there are only narrative reports. But his view ignores the important communications in the patient's nonverbal behavior, the central role of the transference, and the possibility that psychoanalysts, like any group of trained scientists, could check and criticize each other's work. One should not overlook the empirical implications of the phenomena of transference and the observable and predictable unfolding of the psychoanalytic process as conducted by a properly trained psychoanalyst. Through the transference there is a link between Freudian conceptions and natural science so that one cannot, as Ricoeur does, conceive of psychoanalysis solely as hermeneutics and energetics. There are also important natural science phenomena involved in psychoanalysis, which show themselves in the observable behavior of the patient and, above all, in the crucial phenomena of transference. On that point Ricoeur's exegesis has been the most severely criticized by psychoanalysts (Friedman 1976; Holt 1981; Modell 1978; Spence 1982).

#### THE FIVE-CHANNEL APPROACH TO PSYCHOANALYTIC LISTENING

I will now briefly review five standpoints or channels (models, perspectives, frameworks) from which we can tune in to the transmission from the patient (Chessick 1992a). Each of them, as is well-known, is based on premises that are currently conflicting and irreconcilable. The first channel was presented by Freud and focuses on the Oedipus complex and more recently, preoedipal longings. It centers on the emergence in a properly conducted psychoanalysis of the need for drive satisfaction in the transference. This enables us to study the patient's conflict in terms of defenses against the instinctual drives and the resulting compromise formations produced by the ego in dealing with its three harsh masters—the superego, the id, and external reality. Freud's fundamental notion of "drives" has come under considerable attack these days, but, as Anna Freud (1988) said, "Psychoanalysis is above all a drive psychology. But for some reason people do not want to have that" (457). Freud's structural theory was developed for the purpose of delineating and

explicating unresolved intrapsychic conflicts that lie at the root of the psychoneuroses. At the core of the psyche are the patient's childhood or infantile fantasies which repeat themselves over and over again in the patient's mental life and behavior (Arlow, 1985b). We carefully listen for the derivatives of these fantasies and look for them to be reenacted in the transference. I believe this to be the primary model, the starting point for all psychoanalytic listening.

The second channel utilizes the perspective of object-relations theory for its model. The work of Klein and her analysts and Bion focuses on the earliest projective and introjective fantasies of the patient as they appear in the object relatedness manifest in the transference and in the process of projective identification as it occurs in the analytic process. Bion (1963, 1967) emphasized the "toilet function" of the analyst in which the analyst must receive, metabolize, and give back in acceptable form the unacceptable fantasies and affects and expressions of these coming from the patient. Klein (1946) developed the concept of projective identification (defined differently by every author), in which the patient is allowed to place into the analyst whatever representations he or she wishes to place there, with more therapeutic focus on preoedipal fantasies and processes. For Klein, projective identification was also an interactional event in which great pressure is put on the therapist to behave in a manner that corroborates the projection. For Kernberg (1975), aware of Klein's confusion of the intrapsychic and the interactional under one process, it is a very primitive mental event that represents an incomplete projection. A study of projective identification operating in the therapeutic process reveals the patient's earliest internalized object relations and yields data about how the patient as an infant organized these relations into self and object representations and then projected and reintrojected various aspects of these images. Understanding of these processes clarifies the patient's relationships in the present because all such relationships are perceived and reacted to through the filter of these early organized self and object representations.

A third channel, focussing on the patient's being-in-the-world, is the phenomenologic point of view. Here an attempt is made to grasp the facts of the patient's life phenomenologically, without other theoretical preconceptions to organize the data. This approach was emphasized in philosophy by Husserl and then differently by Heidegger, and taken up especially by the pioneer psychoanalysts such as Boss (1963), especially in their effort to understand seriously disturbed and psychotic patients. A corollary of this approach began with Feuerbach and Marx, and was elaborated by thinkers like Fromm, Sartre, and Lacan: society shapes the individual and we can only understand the individual if we understand the society or culture or world in which he or she must continuously live and interact. So, to understand an individual, we must understand that lived state of being-in-the-world which is unique for the situation of each person.

The fourth approach is from self psychology (Kohut 1971, 1977, 1984; reviewed by Chessick 1993), which focuses on the state of the patient's sense of self as it is empathically grasped by the analyst. Important predecessors of this approach were Fairbairn and Winnicott. The latter introduced the notion of the true and the false self that was taken up in detail by R. D. Laing (1969) in his brilliant exposition of schizoid and schizophrenic conditions. Kohut brought the focus on the self into a systematic and elaborate theory; significant alterations in this theory have been offered by Gedo (1979, 1984) and many others. Gedo's establishment of hierarchies of self organization represents a further elaboration and movement away from traditional psychoanalytic metapsychology.

The final approach to organizing the transmission from the patient might be loosely termed the interactive, or relational, or, at its extreme, the intersubjective, focusing on the countertransference of the therapist or, more generally, on the here-and-now factors in the treatment and emphasizing the central role of the analyst's participation. Many of the numerous and conflicting points of view under this rubric have been developed as a response to our increasing understanding, especially in preoedipally damaged patients, of the patient's need for an experience and not just an explanation in the treatment. Gill (1982) emphasized the importance of the therapist's participation in the particular transference manifestations that develop in a given treatment and also focused his interpretations on the here-and-now interaction between patient and therapist. Gill's view is close to Sullivan's (1953) more extreme "interpersonal theory of psychiatry," one in which the therapist both participates in and observes the interaction at the same time. Sullivan's approach suffered from a metapsychological shallowness because of its emphasis on the interactional without sufficient study of the filtering mechanism through which the patient inevitably experiences this interaction. Sullivan's (1947, 1953) concept of parataxic distortion attempts to make up for this, but has not received widespread acceptance. Loewald (1960) was a pioneer in developing the traditional psychoanalytic approach but he also insisted that the patient's experience of the analyst was a major factor in the curative process.

The most complete traditional exposition of the interaction between patient and analyst was offered in a series of papers by Lipton (1977a, 1979, 1983), who restudied Freud's cases in order to demonstrate how significant aspects of the real interaction between the patient and the analyst profoundly affected the data that were presented for psychoanalytic understanding. Freud in his actual practice (often quite sensibly) violated some of his own admonitions published in his (1912a, 1913, 1914c, 1915) papers on technique. Stone (1981) systematized this real interaction under the rubric of the "physicianly vocation" of the analyst and demonstrated compellingly the profound impact of it on the material produced and the process of the treatment itself.

It is likely that Freud's papers on technique were basically aimed at preventing massive acting out by incompletely analyzed or even unanalyzed therapists with their patients, as was common in the early days of psychoanalysis. Freud's admonitions tended, in the middle of the twentieth century in the United States, to become codified into a rigid set of rules that sometimes produced iatrogenic narcissistic manifestations in patients and led to either an impasse in the treatment or a surrender of autonomy by the patient, accompanied by a massive identification with the aggressor analyst; obviously these are unsatisfactory outcomes for a lengthy and expensive treatment.

In the five-channel approach, theoretical orientations or models are being utilized that directly conflict with each other and can not be thought of as complementary because the basic premises that underlie them, both their epistemological foundations as well as their basic assumptions about human nature and its motivations, directly collide. This forces a radical discontinuity as we shift from channel to channel in our receiving instrument, rather than, as we would all prefer to do, sliding back and forth between theoretically consistent positions, or at least complementary positions that are consistent with each other.

The worst mistake a beginner can make at this point in the development of psychoanalytic theory is to assume that in some fashion these five various standpoints can be blended or melded into some supraordinate theory that can generate all of them. Careful examination of the premises of these standpoints reveals that this is simply impossible in our current state of knowledge and we are forced, if we use this shifting of systems, to accept the radical discontinuities. The problem in the human sciences is profound, and some thinkers such as Foucault (1973a, 1973b) have claimed that *in principle* no agreement can ever be reached on a single theoretical model for scientific understanding of all human mentation and behavior.

It may seem to some readers that certain other theoretical approaches or models should be added to these channels; what I am offering here is what has proved in my clinical experience to be of the most value, to be the least speculative (experience-distant), and to generate the least number of arbitrary inferences. The most important requirement of a model is that it be suggested by the very data the patient produces rather than superimposed on the data by experience-distant or arbitrary prior conceptions in the mind of the therapist. This is a relative concept because no theory is truly experience-near, since it is impossible to approach data without some prior conceptions, even in phenomenology. Our only hope is that our conceptions be not too abstract, generalized, and divorced from the specific material, and that they are capable of being validated by a study of how the patient responds to interventions based on them. Of course this is fraught with difficulty, as it is all too human to hear what we wish to hear or infer what we wish to infer.



The hardest part of using this approach is to be willing to keep discontinuous and conflicting models in one's mind, which offends the natural and very dangerous human tendency for a neat, consistent, and holistic theoretical explanation of all material, even if it is wrong. Kant (1781) called this tendency the regulative principle of reasoning, and Freud would have based it on the powerful synthesizing function of the ego. The five-channel approach requires tolerance and flexibility on the part of the therapist as well as a certain maturity, for it is sometimes the unfortunate result of a personal psychoanalysis that the individual becomes a strong and rigid adherent of the particular theoretical orientation or style of one's analyst. Kohut (1984) suggested that the reasons for this are inherent in a psychoanalysis that has incorrectly and prematurely interpreted certain transference manifestations. Since no data available, at present, convincingly and decisively prove any of these theoretical orientations to be the one and only best orientation, uncritical adherence to any one of them would have to be leftover of a misunderstood or unanalyzed transference.

### RELATIONAL PSYCHOANALYSIS

Relational psychoanalysis (Mitchell and Aron 1999), an assortment of views involving interpersonal psychiatry, constructivism, perspectivism, relativism, and more specific types of intersubjectivity such as that of Stolorow and Atwood (1992), challenges the concept of objectivity as an analytic ideal but, as Blum (1998) points out, "Acknowledging the relativity and limitation of objectivity does not diminish its analytic importance" (190).

The term "intersubjective field" was introduced by Brandchaft and Stolorow (1984) and by Atwood and Stolorow (1984) to refer to the fact that diagnosis and meaning in a therapy situation are primarily a function of the mutual interchange between the therapist and the patient. The idea of intersubjectivity is introduced in order to contrast it with the classical positivist notion of the neutral realistic and relatively healthy therapist confronting the emotionally disturbed patient and making an objective diagnosis, a concept analogous to the medical evaluation of a patient with a physical disease.

This approach carries the risk of assuming that diagnoses have no objective validity and are simply a function of the intersubjective field. This is clearly wrong since there is now suggestive evidence for biological and constitutional factors that go into the formation of psychopathology. Brandchaft and Stolorow are well aware of this and have been falsely accused of an untenable position. Stolorow, Brandchaft, and Atwood (1987) have developed their position at greater length, shown its relationship to self psychology, and given clinical illustrations of their approach.

An even more radical view has been presented by Natterson (1991), who claims that the idiosyncratic subjectivity of the therapist “is a basic motivational source and structuring influence in the therapeutic process” (223). In this view there must be continuous self-monitoring by the therapist of his or her individual desires, fears and perspectives brought to the treatment situation, inevitably and constantly exerting a shaping and constituting influence on the transference and treatment process. This is beyond countertransference because it is in addition to it, since it is not stirred up simply by the patient’s transference or personality, but by a host of other factors in the external life and past history of the therapist.

There is a whole spectrum of approaches in relational psychoanalysis that must be kept in mind. At one end of the spectrum is the theory of Freud, in which analysis of the transference neuroses of the patient is central, and an unobjectionable positive transference is assumed to pervade the background of the treatment and is not necessary to be analyzed. The next variation on this is the idea that the personality or gender of the psychoanalyst determines the sequence in which the transferences appear. As we approach the other extreme of the spectrum we have those who say that what is called transference and countertransference is really the action of two transferences on each other to form an intersubjective field. The analysts that I call intersubjectivists argue that the analysis of this intersubjective field—“what is going on between us”—is central to the analysis. In the more extreme view the patient’s childhood is put on a back burner and the implication is very strong that the interpersonal relations in the here and now determine what appear in the therapy, not the transference. At the far end of the spectrum are those who believe that analysts should make self-revelations in an effort to be clear on “what’s going on between us.” This of course carries the danger of constituting an invitation to exploit the patient in a variety of possible ways. From the Freudian point of view it hopelessly contaminates the transference.

Traditional psychoanalysts believe that “the analysis of transference, rather than its exploitation, is still the hallmark of psychoanalytic treatment” (Schlesinger 2003) and the crucial purpose of the psychoanalytic situation is to make the transference show itself. The patient both tells his or her story and reenacts it and the analyst must split into an objective listener and at the same time a figure in the reenactment. At the extreme other end of the spectrum is the experimentation by Ferenczi (1988), in which the patient and analyst took turns being the analyst and the patient, a procedure which is not formally practiced today but which at times tends to happen when there is an exploitation of the transference by the psychoanalyst.

In this book, I use the term “intersubjectivist” or “extreme intersubjectivist” for those psychoanalysts toward the Ferenczi end of the spectrum. The centerpiece of their approach, the focus on the here and now, tends to place

the transference and the childhood experiences of the patient in the background rather than in the foreground where, in my opinion, it belongs. By concentrating on “what’s going on between us,” enactments, and so on, these psychoanalysts carry their notion of the process of psychoanalysis an increasingly great distance from the ideas of Freud. For example, Aron (1999) states:

While a focus on the patient’s experience of the analyst needs to be central at certain phases of an analysis, there are other times, and perhaps long intervals, when focusing on perceptions of the analyst is intrusive and disruptive. . . . Analysts’ continuous interpretations of all material in terms of the patient-relationship, as well as analysts’ deliberate efforts to establish themselves as separate subjects, may be rightfully experienced as an impingement stemming from the analysts’ own narcissistic needs. (257)

Or, as Chodorow (1999) puts it, “Relational, intersubjective, or two-person psychoanalytic approaches, I sometimes fear, take us away from our equally important investigations and conceptualizations of the unbelievable complexity of the individual psyche and unconscious fantasy and of the goals of psychoanalysis” (127). She concludes, “I believe our criticisms of one-person psychologies may have been overdone” (128). Spezzano (1999) says:

I would now have to take into account the reasonable concerns about and objections to the most radical deconstructionist, relativistic, and antiempirical attitudes in some postmodern, constructivist, relational, intersubjective, and hermeneutic writings about psychoanalysis. . . . Although the analyst is not a perfect instrument for observing and capturing the affective states of the analysand, nonetheless, what he observes and imperfectly captures does exist. (457)

The problem with the entire group of theories based on the extreme intersubjective approach is that the external object relationship is emphasized at the expense of what in my clinical experience turns out to be far more important, the intrapsychic self and object representations, compromise formations, and fantasies developed in childhood through which all current adult object relations and objects are viewed, represented, experienced, and responded to. The declaration that the transference is primarily shaped in the present ignores the fact that the transference is basically a revival of unconscious infantile conflicts and more or less traumatic experiences and precognitive memories, which have been worked over during infancy into archaic core fantasies (see Arlow 1969a). In a sense, the patient evolves certain fantasies in infancy that include crucial intrapsychic self and object representations that

will then emerge in the transference. Therefore the transference primarily represents the regressive repetition and revival of the past through the displacement of and/or projection of the unconscious fantasy objects and relationships of infancy and childhood onto the psychoanalyst.

### INTERSUBJECTIVITY

It is very important to make it clear to the reader that I understand there are many forms of relational psychoanalysis and that in every psychoanalysis there is always some discussion of what is going on between the psychoanalyst and the patient and an attempt to analyze enactments, et cetera. However, when one shifts the focus of the psychoanalysis on a relatively consistent basis to the interpersonal interaction between the patient and the psychoanalyst one places the analysis of the transference and the exploration of childhood fantasies and conflicts as they reveal themselves in free association, dreams, and so on, on the back burner. Those forms of relational psychoanalysis that tend to do this I have labeled, in this book, “intersubjectivity” because of their deliberate and sometimes exclusive concentration on the here and now in the relationship. I am not setting up a straw man here; although very few analysts go as far as Ferenczi did, there are many psychoanalysts today who have shifted their practice much in the direction to that end of the spectrum and it is the extremes of this shift which are appearing in the literature and in my clinical work with patients who are consulting me for a second analysis. These extremes, to my mind, represent a different form of psychotherapy than the psychoanalysis that was invented by Freud and which was based on the various clinical and philosophical assumptions that were the foundations of Freud’s conceptions. This group of extreme intersubjective psychoanalysts, one that is increasing in influence and proponents today, are discussed in this and later chapters, and I delineate how they affect the future of psychoanalysis.

The debates between traditional and relationist views of psychoanalysis form a subclass of the current unresolved philosophical question of whether there is hope for human knowledge between the Scylla of relativism and the Charybdis of absolutism (Blackburn 2005). Somehow, if psychoanalysis is to have a future, we must steer between these extremes. The point of this book is that we psychoanalysts are drifting today too far toward the Scylla of relativism, perhaps as a reaction to Freud’s tendency to the Charybdis of absolutism that became the ossified model of the psychoanalyst in the mid-twentieth century. This endangers the future of psychoanalysis and, as some philosophers (Boudon 2005) have pointed out, can shipwreck “our science” on the rocks of nihilism, chaos, mysticism, and disrepute.

In previous publications (1995a; 1996a), I have pointed out how intersubjectivity tends to slide over into nihilism. It even challenges all theory construction, for if there is no objective and consensual observation of clinical facts possible, one can not build any theories and test them against clinical data. The point I am making is that regardless of the idiosyncrasies of various analysts, and assuming that the analysts we are paying attention to have received a thorough personal psychoanalysis of their own and therefore are bringing only sliver patient vectors into the treatment, it is possible to accumulate a body of analytic findings which can be checked “against findings with different patients, with different analysts, and in analytic observations and studies outside the analytic situation” (Blum 1998, 194–195). Furthermore, emphasis on the intersubjective, on the here-and-now aspects of the therapy, while certainly having value, can easily represent a flight from the emergence of both the patient’s and the therapist’s unconscious conflicts and core fantasies.

Although enactments inevitably occur and are sources of understanding countertransference, a powerful debate continues as to whether these enactments and the analyst’s unintentional emotional involvement are the most important curative aspects in psychoanalysis. Whitaker and Malone (1953) point out that all psychotherapy involves a therapist and a patient who have what they call both therapist and patient vectors in them that work on the level of the apparent as well as the unconscious relationship between patient and therapist. Therapist vectors are responses to the needs of the immature child part of the other person. Most often the responses of the therapist are therapist vector responses to the patient. At times, however, the patient responds with therapist vector responses to the (we hope) relatively small residual child part of the therapist. Patient vectors are archaic demands for a feeling response from the other person, much as a young child urgently demands response from his or her parents. Clearly, patients will get well only if the patient vectors of the therapist do not make excessive demands on the patient’s therapist vectors, but Whitaker and Malone then make a rather startling point. They insist it is vital for successful psychotherapy that the therapist bring in his or her patient vectors along with his or her therapist vectors. They call this a total participation with the patient, a concept also emphasized by Little (1957) as necessary before the analyst’s interpretations can be meaningfully heard. Both the analyst and the patient have characterological defenses against such participation, which carries great vulnerability, that must be worked through before effective explorations of the past can begin. The therapist thus expands the frontiers of his or her own emotional growth during the therapy.

If the therapist refuses to participate totally in this fashion, it is experienced by the patient as a severe rejection, or, in self psychology terms, a massive

empathic failure of the selfobject, and the therapy is not successful. In a more extreme view, Boesky (1990) states: "If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis would not proceed to a successful conclusion" (573). It is clear that this becomes an extremely important issue if we agree that, for a psychoanalysis to be successful, some sort of unplanned and spontaneous participation on the part of the analyst is necessary and unavoidable, perhaps arising from unformulated countertransference (Chessick 1999a), or perhaps from a sort of "pre-conscious attunement" (Kantrowitz 1999), but always requiring "the analyst's self-discipline to preserve the analytic role and keep the treatment safe for both participants" (65).

McLaughlin (1987) describes how "The incessant play of nonverbal activity between patient and analyst actualizes and amplifies the primary verbal data of the psychoanalytic dialogue" (557). Renik (1993) presents the most extreme view of this, claiming that "an analyst's activity, including how an analyst listens and all the various moment-to-moment technical decisions an analyst makes, is constantly determined by his or her individual psychology in ways of which the analyst can become aware only after the fact" (559). In that sense he agrees with Boesky and points out that "*unconscious* personal motivations expressed in action by the analyst are not only unavoidable, but *necessary to the analytic process*" (564).

But it is quite possible that these factors can also impede or defeat an analytic process! For I define the analytic process as occurring in a situation in which the analyst, attempting to be as objective and neutral as he or she possibly can be, and listening and interpreting on multiple channels that shift as the patient's material indicates, facilitates the emergence of transference phenomena that illuminate the patient's infantile core conflicts and fantasies. So Blum (1998) writes, "In the classical tradition, the relatively objective and neutral analyst permits clarification of the patient's fantasy distortions within a grounded rather definitive reality." But, he adds, "If countertransference is intense and intrusive, if the analyst validates or fulfills the patient's fantasies, or if the analyst behaves like the patient's childhood objects . . . then analysis of transference can be impaired" (197). One of the reasons it becomes impaired is that the patient cannot contemplate the transference if it is being enacted in some major fashion through the analyst's countertransference, instead of being identified and interpreted.

Although it is true that patients will hang the transference on various peculiarities of the analyst, I believe the primary source of the transference comes from infantile core fantasies and unconscious archaic psychic structures. The emergence of these in the transference needs to be continuously studied by both the patient and the analyst. The archaic remains a vital and often disruptive or self-defeating primordial force, an active past at any level

of development. The exceptional emphasis by intersubjectivists on the cocreation of both analytic data and the transference loses sight of this central proposition of Freud's psychoanalysis since, as Blum (1998) explains, "The current object relationship of the coparticipants takes center stage, and infantile conflicts recede into relative obscurity or unimportance" (199).

I regard psychoanalysis as retaining a scientific core, based on the observation of emergent transference phenomena. As an ideal, it is important for the analyst to maintain what might be called good-enough objectivity and good-enough neutrality in order to allow transference manifestations to emerge, especially the archaic transference manifestations which often have only a small connection to the idiosyncrasies of the properly analyzed analyst's personality, for example, such archaic fantasies of the analyst as a serene Buddha, the analyst as a god, as possessing magical powers, as omniscient, and so forth.

The matter is actually more complicated than I have expressed it here so far. The phenomena of transference cannot be understood merely by empirical observation, although this is the obvious natural sciences starting point. There is more to it, however, because in order to achieve a firm and continuing grasp of the transference, the analyst must be able to have and to be motivated to exercise a self-reflective receptive capacity, characterized by a willingness to maintain a state of reverie akin to that advocated by Bion, until certain unformulated or inarticulate conceptions begin to float across his or her consciousness. These are countertransference manifestations stirred up or placed in the analyst by the patient's transference, for example, through projective identification and the patient's need to recreate certain crucial childhood relationships, sometimes playing the role of the parent and sometimes of the child. So the analyst must always, besides exercising the psychological self-receptive process, also be silently asking himself or herself what role is being pressed upon the analyst and how the patient is attempting to use the analyst, what is expected, what is anticipated, and what is experienced through the filter of the patient's childhood core fantasies and representations.

Bollas (1987) compares this to the mother's capacity to grasp the inarticulate sensations and feelings of the child and transform them into verbal representations that can be mutually considered and negotiated. The capacity to do this by the analyst also provides the patient with a new and more mature object for internalization, and hopefully the very process of self-reflection will be internalized. This capacity is one of the hardest functions to teach candidates. A certain innate talent is required and also a certain psychological mindedness and comfort with uncertainty, dreams, fantasies, and desires. Freud (1926) correctly complained that medical training tends to marginalize this function in order to stress external observation in the study of physical illness, a long and time-honored tradition in medicine. Anyone who has tried to

help new residents in psychiatry grasp these concepts will attest to the truth of Freud's complaint, and I think it explains why contemporary psychiatry clings so tenaciously to a shallow Kraeplinean orientation, a kind of pseudointernal medicine.

Even more unfortunately, there is a trend among analysts today away from this procedure. As Yorke (1995) complains:

They do not relax and give themselves up to free-floating attention. They do not, for example, find that appropriate associations attuned to those of the patient come readily to mind, that one of the patient's remarks recalls another that gives it fresh meaning, or that a fleeting thought touches something in their own unconscious that points to a deeper or more primitive context than the one which the patient consciously presents, or that a patient's immediate fantasy spontaneously recalls in the analyst's mind something said in a session days or weeks ago. Rather . . . they give the impression of sitting on the edge of their seats as they try to make sense of what the patient tells them. They try to fit it into a theoretical framework and feel vindicated when the "fit" is a good one. (25)

Even Renik (1998), who has been one of the most outspoken advocates of intersubjectivity in the analytic situation, still regards psychoanalysis as a science. This is because he believes we can, although imperfectly, evaluate our interpretations on the basis of their predictive capacity. He writes:

When I suggest to a patient that he is burdened by irrational guilt feelings, I can see whether his mood improves; or when a patient and I conclude that she no longer needs to be afraid of being more sexually potent than her mother, we can see whether she will begin to be able to have orgasms during intercourse. The circumstances under which psychoanalysts can make predictions can be poorly controlled, and definitive empirical evidence for a psychoanalytic proposition may be very difficult to obtain, but hypotheses-testing via prediction is possible in psychoanalysis. Therefore psychoanalysis is a science. (492–493)

So in spite of the emphasis on intersubjectivity, it does not follow that objectivity is impossible to achieve in clinical psychoanalysis. The fact that there is a testable and predictive value to the meanings that are interpreted in the psychoanalytic process also distinguishes psychoanalysis from pure hermeneutics, where the criteria of valid meaning do not include subsequent empirical experiences and psychological material.



Gabbard (1997) reminds us that there are a whole variety of differing approaches grouped under the loose heading of “intersubjectivity.” The danger of intersubjectivity, he points out, is the privileging of the patient’s subjectivity. He stresses the importance of the analyst’s perspective being different from that of the patient’s internal experience and the developmental value of that difference, just as in infant development the subjective object is transformed into an objective object, “one that is partly created by the infant and partly the by-product of the infant’s increasing attunement to the *actual* characteristics of the mother as an external object with her own subjectivity” (18).

The heart of the matter goes back to Freud’s (1912b) description of how the patient’s template is repeated again and again in the transference. As Gabbard (1997) explains:

Although the analyst’s subjectivity influences that template to some degree, there are nevertheless transference patterns that are characteristic of individuals. The patient’s intrapsychic conflicts and internal object relations were forged long before entering analysis and will find a way to make themselves known, regardless of the analyst’s contribution. (22)

The crucial point is that the early object representations and characteristic processes of object relations that are internalized in the patient’s psyche will appear in the analytic process in one sequence or another depending on the subjectivity of the analyst, but they will appear, and will appear in a reanalysis with a different analyst, assuming the psychoanalysts are competent.

### THE ANALYST AS A NEW OBJECT

Psychoanalytic technique involves free association, frequency, regularity, recumbency, the analyst’s special way of listening, relative neutrality, abstinence, and interventions primarily involving interpretation and analysis of transference. Starting from the current surface of the material and working in increasing depth, we hope for reconstruction of pathogenic experiences or deficits from the past and uncovering the core fantasies and other compromises that were evolved to deal with them. We recognize the powerful effect of the real person of the analyst and the intensity of his or her emotional involvement with the patient over many years, but whereas in psychotherapy this is deliberately utilized along with the transference, in psychoanalysis the transference is hopefully identified and interpreted along with its genetic roots.

The role of a new object experience as constituting the silent power of psychoanalysis, and the relationship as integral to therapeutic change especially

with sicker patients has been increasingly recognized. These patients are characterized by unreliability of object constancy, “failure to tame drives or to develop stable defenses, deficiencies in self-esteem, in frustration tolerance, in affect modulation” (Pine 1992, 252), and at times a blurring of reality testing and self and object boundaries. In psychotherapy, supportive elements are moved to the foreground of the interaction, whereas in psychoanalysis the holding environment forms the background. A shifting back and forth may be necessary, depending on the vicissitudes of the patient’s state.

After-education is very important in the analytic process, as is the analyst functioning as a new object providing a corrective reparative experience (Loewald 1960) or transformative experience (Bollas 1987). I do not see how this can be avoided, or even that it should be, but it is a genetic fallacy to think that the interchange between the analyst and the patient has the same direct affective impact as the interchange between a caretaker and an infant. Adult affects and object relations are not isomorphic with their infantile precursors because the former are experienced entirely through the schemata of intrapsychic representations and fantasies established during infancy and childhood. Furthermore, the benefits to the patient from experiencing the analyst as calm, collected, tactful, tolerant, and dedicated are clearly not the same as those benefits arising from “the crucial addition of technical neutrality and relatively objective analytic interpretation of unconscious conflict and trauma” (Blum 1998, 201), as this intrapsychic material is regressively revived and even relived in the psychoanalytic process.

Shane, Shane, and Gales (1997) base their theoretical approach to psychoanalysis on the premise that the salutary effects on development of the mother-child interaction can be also produced by the analyst-patient interaction. Recognizing the uncertainty of this premise, they ask: “Can such a significant and far-reaching development take place in an adult or a child through the analytic experience itself, based on understanding, insight, and a living-through relationship with the analyst? We believe it can” (99). But they require of the analyst, if this is to happen, “Availability, concern, positive responsiveness, positive regard, a commitment to the patient’s well-being, and an encouraging attitude in regard to all the patient’s struggles and conflicts, as well as wishes and desires” (99). This is very nice, but how does it distinguish psychoanalysis from any other form of physician-patient relationship? Sometimes understanding and insight are actually blocked or defended against by various physician-patient enactments, and sometimes the analyst’s attempt to be so empathic and actively produce and even report such loving and caring attitudes to the patient can hide countertransference phenomena. The kind of self-revelation recommended by these authors can easily be used in an unconscious collusion to gratify narcissistic and exhibitionistic needs of the analyst, of the patient, or both. For example, in an admittedly extreme view, they rec-

commend that in certain instances, if a patient says “I love you,” and you love the patient you should tell the patient so, forming a “nonsexual attachment” in this manner. Freud, of course, would scoff at even the possibility of such an attachment, and he might sarcastically ask how to respond when a patient says “I love you,” and you do *not* particularly love the patient. Do you say “I do not love you”? What do you say in the latter situation that is not either a lie or a humiliation for the patient, if you have already conditioned the patient to expect self-revelatory responses? All this is a rerun of the well-known admonitions Freud gave to Ferenczi when the latter tried physical interaction with his patients; how easily one thing leads to another in boundary crossings! Psychoanalysis of this sort can dangerously disintegrate into a kind of hand holding and love therapy, which is often what patients want and which unanalyzed therapists will sometimes provide in order to avoid having to face the patient’s or the therapist’s rage and negative transferences or countertransferences.

### THE DATA OF PSYCHOANALYSIS

There is a dangerous fallacy in the extreme intersubjective as well as those hermeneutic viewpoints that assume the centrality of continual cocreation of the data of psychoanalysis. The notion of “cocreation” shifts our attention away from the patient’s ownership of unconscious conflict and archaic fantasy, and moves our focus away from pathogenesis and toward iatrogenesis. Patients enter analysis with character pathology that has developed as a set of compromise formations and defenses against the drives and experiences that produced early infantile conflicts and archaic fantasies. They present these at the onset of analysis, sometimes even from the very first telephone call in making an appointment; these are not created or cocreated in analysis. The centerpiece of psychoanalysis is to uncover and understand the persisting influence of earlier developmental phases and the conflicts and archaic fantasies these have produced, through the regressive revival of them in the analytic process. In so doing, we have to assume that the good enough psychoanalyst has at least an adequate capacity to retain objectivity toward the patient and toward his or her own countertransference. It is this assumption that forms the basis of my contention that Freud’s psychoanalysis is primarily a science with a future, that reliable data can be collected over the years by many well-trained analysts working with a variety of patients, and that on the basis of these data reliable theories may be formulated that can then be extrapolated to the treatment of other patients.

In spite of a number of papers by a variety of prominent psychoanalysts attempting to replace Freud’s drive theory, it remains an extremely valuable heuristic notion to help us in thinking about our patients and about our

unfortunate species in general (Chessick 1996c). It is reassuring that such well known psychoanalysts as André Green and Leo Rangell agree with me about this (see Raymond and Rosbrow-Reich 1997). Yorke (1995) points out that Freud's metapsychological concepts "although capable of modification in the light of fresh clinical and theoretical findings are, in their fundamentals, indispensable. . . . Critics of metapsychology seem to lose sight of the purpose of metapsychological concepts. They are explanatory concepts, means to an end and not ends in themselves" (3, 23). Perhaps it would be important here to clarify Kant's notion of "heuristic principles," as he used them in his (1790) *Critique of Judgement*. This notion was also taken up by Einstein, who called them "heuristic viewpoints," serving the purpose of allowing us to make assertions from which familiar facts could then be deduced. Heuristic viewpoints, for example, drive theory, cannot be directly falsified or proven; their value is in their usefulness in explaining familiar facts, such as the overwhelming human preoccupation with lust and aggression that makes up what Hegel (1840) called the "slaughter bench" of history, "upon which the happiness of nations, the wisdom of states, and the virtues of individuals were sacrificed" (24). Our greatest novelists are our greatest psychologists. Consider this statement by Captain Ahab (Melville 2002):

What is it, what nameless, inscrutable, unearthly thing is it; what cozening, hidden lord and master, and cruel, remorseless emperor commands me; that against all natural lovings and longings, I so keep pushing and crowding, and jamming myself on all the time; recklessly making me ready to do what in my own proper, natural heart, I durst not so much as dare? (406)

From my point of view, that of the post-Freudian psychoanalyst in what Wallerstein (1995) calls the post-ego-psychological age, the psychoanalyst does indeed regard everything in the mind and even one's character patterns as compromise formations between drives and repressing forces, but he or she is extremely judicious as to which compromise formations require analysis. This is the way deconstructionist and constructionist aspects are combined in any psychoanalytic therapy. The art of therapy is to know what to analyze and what to leave alone, and to develop the proper timing and phrasing of interpretations and other interventions so that the whole experience does not appear to the patient to be coming from a torture chamber and constitute a perpetual humiliation and destruction of self-esteem.

What is currently missing is a genealogical study of why, in certain cultures, certain types of psychoanalytic theories tend to predominate. For example, in South America, Kleinian theories, peppered with the ideas of Lacan, are the current fashion. Lacan's version of Freud swept like a tidal wave over

France a few years ago. In the immediate post-World War II United States, Hartmann's (1958) ego psychology was the fashion. In our current cultural milieu, one of affluence, global capitalism, and extravagant consumerism, a hedonistic and pleasure-oriented culture that emphasizes fast-fast-fast relief and the relativity of all moral and ethical principles, a plurality of theories and schools and various forms of intersubjectivity have come to be the fashionable basis of psychoanalytic theory formation.

There is also an important financial explanation for this, since the more one views psychoanalysis as a form of hermeneutics, the less one needs to view it as a scientific medical discipline, opening the door, as happened in France with the advent of Lacanianism, for everyone to feel free to practice what they call "psychoanalysis". What this has led to is not a flourishing of psychoanalysis but a marginalizing of it in our society, a loss of respect for it, and the provision of an opening for insurance companies to deny payments for analytic treatment. The net result of this has been a disaster for many troubled individuals who need prolonged psychoanalytic therapy and with the advent of so-called managed care no longer have the means to provide it. This situation also entails a loss of reliable and detailed information from the deep analysis of many psychoanalytic cases by highly-qualified psychoanalysts.

The philosopher Adorno (1973) outlined three forms of what he called negative dialectical thinking, which may help us in untangling the difficult problems involved in trying to derive truth from the data of psychoanalysis. One of these forms is what he calls the internal critique. Adorno and the other members of the so-called "Frankfurt School" argue that the Enlightenment was predicated upon an epistemological error, namely the idea that our knowledge can fully capture reality, and understanding can be determinate. They believe this error leads to an impoverishment of rationality and finally to its collapse. It is the kind of error, for example, involved in trying interminably to specify *exactly* what is psychoanalysis and what is not psychoanalysis. Adorno maintains that our representations of reality always entail some level of indeterminacy. We know that conceptual thought is limited, and we also know there is a discrepancy between any concept of something and the object itself, a discrepancy we can understand through the use of what Adorno calls "non-identity." Nonidentity refers to that part of the concept which does not fit the object and is therefore misguided and superfluous, but it also negates the concept. Conceptual systems such as Freud's drive theory or his tripartite model of the psyche, then, are valuable and indispensable to give us direction and motivation and they are a part of the dialectical process of understanding. They contain what I have called a heuristic value and we cannot do without them. The contradictions that occur between our clinical experience and our conceptual systems are the way in which we get closer to understanding, but we cannot focus as we should on these contradictions if we assume that our conceptual

systems are congruent with the whole truth. This is the first form of negative dialectics; it is the contradictions that take us closer to understanding.

Adorno's second form of negative dialectics he calls constellation, in which one attempts to get to a deeper discernment of the object, or the patient in our instance, by emphasizing the shortcomings of a whole variety of differing conceptual systems that are employed by various individuals or schools of thought in their study of the object or patient. This is the epistemological basis of the five-channel theory of psychoanalytic listening reviewed above, in which I propose that we need to listen to patients (and ourselves) on several channels at a time, each of which are based on differing and conflicting conceptual systems, in order to have a better understanding of the patient.

The third form of negative dialectics, close to Kohut's notion of empathy, consists of what Adorno calls mimesis. This is a form of cognition distinct from conceptualization, an attempt to identify with the object, that is, one's self identifying with the other by becoming in imagination like the other. Elsewhere I, have discussed the whole special and controversial issue of empathy as a form of psychoanalytic investigation (1998). There are no clear or set rules for mimesis but rather an indefinite number of imaginative responses. Mimetic identification is neither precise and exhaustive nor fully comprehensible; it is open to continuous interpretation and its meaning is inexhaustible.

I believe our approach to the patient should employ all of these techniques, and when we are able to do so we have a more balanced and appropriate view of the individual who is coming to us because he or she is suffering; who is enslaved to an infantile fantasy life and poor maladaptive childhood compromise formations as well as manifesting what Gedo (1988) calls "apraxias," a lack of certain basic skills in human adaptation. These "apraxias" may be viewed as manifesting themselves in another form of the transference, the interpersonal situation the patient creates with the analyst. Here again, the main contribution comes from the patient, as what Fonagy (1999) calls "procedural memories" are attempted to be reenacted in the relationship with the analyst, sequences of actions and pressures brought upon the analyst, who needs to recognize and interpret these to the patient. But although the personality and theories of the analyst have a role in the appearance of these memories and the way in which they appear, in my opinion it is an error to ignore what the patient is attempting to tell us about the past, which the patient would tell in one form or another regardless of the specific analyst, if given a chance to do so.

It is our task as psychoanalysts to deal with all of this and to not get caught up in two of the cardinal errors that Adorno talks about. These are hypostasis, which occurs because once a theoretical system is developed it is believed that system has fully captured everything about the object and no further thought is needed or evoked; and rigidity, in which a system tends

to become fixed. Not long after that, schools are set up, schisms develop, leaders and apostles appear, and we have the psychoanalytic civil wars (Frosch 1991).

Reporting on a discussion of the topic “One Psychoanalysis or Many?,” Hanly (1997) summarized Rangell’s central proposal as being that, “psychoanalysis as a body of knowledge is . . . an evolving, unitary, coherent, composite theory, whereas contemporary psychoanalytic culture makes it out to be a collection of alternative, inconsistent, but equally viable theories” (485). Theoretical plurality in our field, Rangell is reported to have said, is more a matter of political and bureaucratic matters and is not based on any established scientific validity. A study of these political and bureaucratic matters surely ought to be the subject of a thorough investigation by future scholars.

Hanly asks:

Why is psychoanalysis so vulnerable to charisma and group identifications? Psychoanalysts, rather like philosophers, seem to adopt theoretical positions for reasons other than the strictly rational ones of fact, logic, and explanation. . . . Is this a consequence of failure to analyze the idealizing transference, so that analysts are exposed to basing their theoretical views on a personal affiliation rather than on clinical observation? (486)

He continues:

I take Freud’s theory to be the core of a unitary psychoanalytic theory . . . I continue to consider Freud’s durable theories to be the best empirical hypotheses available for this purpose and, therefore, consider them like any empirical hypotheses to be subject to continuing clinical testing and logical evaluation. The formulation of new explanatory hypotheses in the form of alternative theories is an essential part of this endeavor to improve and develop psychoanalysis. It is the preference for the easy, exhilarating transformation of new and old theories into charismatic ideologies that causes a failure or refusal to engage in this difficult, painstaking work. (488)

I do not think the Enlightenment project is bankrupt. It is in need of some revision, but future human emancipation and freedom still have the best chance of developing through the exercise of reason. It is incorrect to say psychoanalysis in the contemporary world is generally dismissed as a relic of a bygone age. This is somewhat true in the United States where the

pharmaceutical corporations, insurance companies, and managed care tyrannies have been able to dominate United States psychiatry, but it is not true in South America, it is not true in continental Europe, and psychoanalysis is currently enjoying exploding interest in Russia and Japan. There has been remarkable growth especially in France, Germany, Italy, Argentina, and Brazil. There are today a number of critics of Freud who are notorious in their hatred of psychoanalysis but Freud has always been viciously attacked by prominent critics ever since his first publications. Psychoanalysis is a threat in a commercialized society in which a quick-fix mentality reigns and a greater premium is placed on conspicuous consumption than on self examination. More generally, as Chasseguet-Smirgel (Raymond and Rosbrow-Reich 1997) puts it, "there exists a struggle against psychoanalysis which is one with the struggle against thought itself. A denial of the unconscious is in keeping with the dehumanized world in which we live" (462).

Certain authors set up a straw man, the so-called orthodox psychoanalyst who dogmatically believes that his work is pure nineteenth-century science, who does not accept the fact that conflicting theories in our field are legitimate because he considers his own theory to be the only "truth," and who does not make any effort to think about his own contributions to the therapeutic material and to reflect on the unsolved problems of psychoanalysis. These authors have missed the general shift in even the most traditional psychoanalytic literature over the past twenty years, in which the most prominent analysts are wrestling with these problems (see Wallerstein 1995). A number of authors (e.g., Pine 1985; Chessick 1992a) have suggested that multiple theories are necessary in psychoanalysis although these theories are epistemologically conflicting. The harsh critics of psychoanalysis have only addressed selected aspects of it and have neglected the contributions of postclassical analysts. But we are all postclassical analysts these days and there are few if any dogmatic Freudians left.

Only the most poorly trained and inadequate psychoanalysts attempt to fit analysts into a Procrustean bed of authoritarian rigidly established psychoanalytic concepts and procedures, fostering compliance. Kohut (1977) would consider this a massive failure of empathy, and he (1984) stated in his posthumously published work that actually the particular theoretical orientation of the analyst is not as important in psychoanalytic healing as is the analyst's capacity to be empathic with what is hurting or narcissistically wounding the patient at any given time, regardless of the language the analyst uses to communicate that empathic understanding to the patient.

The fact that some of the phenomena generated in the analytic process cannot be traditionally scientifically replicated does not demonstrate that psychoanalysis is not a science; it simply demonstrates that like all sciences, psychoanalysis can only provide a limited picture and is subject to the continual



process of alteration and modification of Freud's theories over the years as our empirical knowledge grows out of our clinical work. It is very dangerous to the future of psychoanalysis to divorce it from its biological or even quasi-biological roots such as drive theory, to ignore its scientific foundations, and instead to try to characterize psychoanalysis as some sort of purely hermeneutic or intersubjective discipline in which "the focus of therapeutic action goes from an authoritative therapist interpreting the patient's unconscious roots, to a therapist engaging the patient in a kind of corrective emotional experience, involving a mutual resolution and discovery of unconscious interferences in both therapist and patient" (Feinsilver 1999, 281). This postmodern approach runs the serious risk of encouraging a total relativism, subjectivism, cultism, mysticism, and hopelessness about the progress of the field as well as an increasing derogation of it in the mind of the public and a subsequent marginalization of it in our society.

Psychoanalysis is evolving and changing as every science should, while psychotherapy today is riding off madly in all directions in an attempt to bend itself to fit the inhumane demands of managed care and so to stay in business. There are hundreds of forms of psychotherapy, most of them practiced by poorly trained individuals who have only a foggy idea of what they are doing. I believe this is what can be expected of psychotherapy in the future since there are no criteria agreed upon and no certification examinations that one needs to pass in order to call one's self a psychotherapist. Psychoanalysis, however, is and should be much more strict and is continuously making a serious attempt to define itself.

One of my most influential teachers, Franz Alexander, argued that psychoanalysis and psychoanalytically oriented psychotherapy were procedures that gave operational meaning to the motto of the Renaissance humanists: respect for the dignity of the individual. In his (1964) last and posthumous publication, he wrote:

Psychotherapy aims not only at enabling a person to adjust himself to existing conditions, but also to realize his unique potentials. Never was this aim more difficult and at the same time more essential. Psychoanalysis and psychotherapy in general are among the few still existing remedies against the relentlessly progressing levelization of industrial societies which tend to reduce the individual person to becoming an indistinguishable member of the faceless masses. (243)

Psychoanalysis is no longer a lucrative discipline; most psychoanalysts confess that much of their practice is now taken up by the practice of psychotherapy. Only a small percentage of well-trained psychoanalysts are dedicated enough to confine their treatment to full scale three or four times weekly

psychoanalysis, which often requires them to treat patients at very reduced fees since insurance help for such treatment is now almost completely unavailable. It is to this dedicated group of psychoanalysts that we must look for the future development of the discipline as a science, as a legitimate means for scientific exploration of the human psyche that was the guiding vision of Sigmund Freud.