Psychoanalysis at the Millennium*

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This article explains and discusses the immense complexity of the psychoanalytic process as it is becoming increasingly understood at the millennium, and offers the possibility that it can be viewed from at least five channels of psychoanalytic listening. The careful ongoing examination of the transference-countertransference interactions or enactments, and their “analytic third” (32) location in the transitional space is extremely important in psychoanalytic practice. We must be careful in our interpretations of the clinical data not to stray any farther from the fundamental concepts of Freud than is necessary, lest we end up with a set of conflicting speculative metaphysical systems and become a marginalized esoteric cult. Freud’s work remains our basic paradigm, the core of psychoanalysis, even though his papers on technique and his emphasis on the curative power of interpretation are from a one-person psychology standpoint and his view of psychoanalysis as just another empirical 19th-century science requires proper understanding and emendation in the light of accumulated clinical experience since his time.

I ask you what sense do these old quarrels make for us? The profound resentment of unbending partisans has kept the wounds of our congregations open for far too long, wounds whose deadened flesh has become insensate, so we feel no need for the doctor.

St. Augustine

The above quotation is from a letter written by St. Augustine (1, p. 77) about 395 A.D. in his effort to reach some kind of reconciliation with the Donatists. Both the Donatists and the Catholics shared a great many basic principles at the time but the Donatists, named after Donatus, a martyred hero of the resistance to any compromise, were known as stubbornly refusing to negotiate or yield even on the smallest details of their theological doctrines. As a result, Augustine’s efforts failed and he ended up resorting to traditional Christian solutions—violence, restriction of civil

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liberties, and deportation—in an effort to stamp out this heresy (which nevertheless lasted until the 7th century A.D.).

So it is that plus ça change, plus c’est la même chose, the more things change, the more they remain the same: When I was a resident in psychiatry we had a series of seminars by one of my most influential and revered teachers, Franz Alexander, who could be counted on to discover in each and every case presentation, regardless of the material or diagnosis, that the nucleus of the disorder was an Oedipus complex.

With all this high-powered psychoanalytic training, information, and experience gathered in my residency, after spending two years doing military service in the United States Public Health Service working with drug addicts in a federal prison, I entered into the full time private practice of psychoanalytic psychotherapy in 1960. At this point, I encountered a fascinating schizophrenic patient who was not so schizophrenic that I could not stand her, and who, after several years of intensive psychotherapy, made a very noticeable recovery and adaptation that enabled her to live a reasonably decent life in our lunatic culture. Bursting with pride near the end of the treatment as I had watched this woman evolve from a dilapidated human wreck into a very presentable and now married young lady, I could not refrain from asking her, near the end of the treatment, which of my interpretations had had the most significant impact on her improvement and development. Her response was, “You have kind eyes.”

This took me down a considerable distance and set me thinking about what it is that actually brings about a cure in psychoanalytic treatment and about what sort of theoretical orientation is most suitable for what I (2) believe to be first and foremost a clinical medical discipline. I gradually began to think of my patients and their narratives as sort of Rorschach cards on which a variety of theories may be imposed. Kohut (3) tried to distinguish between experience-distant and experience-near theories, but this proved to be simply more narcissism on the part of psychoanalysts, because now we know that all theories are experience-distant, and it is in the area of theories that there is the most argument. So the philosopher Epictetus, in his classic treatise Encheiridion (“Manual,” 100 A.D.), gave us an aphorism that Laurence Sterne thought was so worthwhile that he used it as a motto in his famous novel Tristram Shandy, published around 1760: Tarassei tous Anthropon ou ta Pragmata, Alla ta peri ton Pragmaton Dogmata, which I roughly translate as meaning “people are not disturbed by things, they are disturbed by theories about things.”

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FIVE CHANNELS OF PSYCHOANALYTIC LISTENING

Over a period of 25 years, from about the 1970s to the present, I gradually evolved what I have called the five-channel theory of psychoanalytic listening. I have published a book (4) and a number of papers (5, 6) on this topic and so I will only very briefly review here the five standpoints or channels or models or perspectives or frameworks from which I suggest we tune in to the transmission from the patient. The first was presented by Freud. It involves the Oedipus complex and the emergence in a properly conducted psychoanalysis of the pressure for drive gratification 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 structural theory, placing the Oedipus complex at the focus of all psychoneuroses, was developed in order to best depict this one-person standpoint; the analyst is thought to be simply the observer of it all.

The second channel utilizes the perspective of object relations theory for its model. It is based on the work of Klein and her analysand Bion, and focuses on the earliest projective and introjective fantasies of the patient as they appear in the object relatedness manifest in the transference, and on the process of projective identification, which is defined differently by every author. Understanding of these processes through a conceptualization of the patient's earliest internalized object relations 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. This helps to clarify the patient's relationships in the present, because all such current relationships are perceived and reacted to through the spectacles of these early organized self and object representations.

A third channel, focusing 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. A corollary to this approach is that 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 Kohut's self psychology, 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 (7) in his brilliant exposition of the phenomenology of schizoid and schizophrenic conditions.

The final approach to organizing the transmission from the patient might be loosely termed the interactive, focusing on the countertransference of the therapist or, more generally, on the here-and-now factors in the treatment with emphasis on both the patient’s and the analyst’s participation, from what is designated as the two-person standpoint. This is the domain of intersubjectivity and postmodernism, popular as we go into the 21st century. Many of the numerous and conflicting points of view under this rubric have been developed as a response to our increasing understanding, especially in pre-oedipally damaged patients, of the patient’s need for an experience and not just for an explanation in the treatment, as Frieda Fromm-Reichmann (8) put it.

Hans Loewald, for example, although he was a pioneer in developing the traditional psychoanalytic approach, was also a student of the philosopher Heidegger. Loewald (9) insisted that the patient’s experience of the analyst was a major factor in the curative process. Hence, the patient’s metaphor, “kind eyes” begins to make some sense. This is especially true in patients who present us with archaic transferences that actually force us to make immediate decisions about what to do, for example, having to decide whether to try to put a stop to a patient’s suddenly developing promiscuous behavior in the age of AIDS.

Anyone who was a patient of Sigmund Freud had quite an experience of the personality of his analyst. Freud was anything but neutral and opaque, and certainly Freud in his actual practice often, in my opinion quite sensibly, violated some of his own admonitions published in his papers on technique. 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 certainly common in the early days of psychoanalysis and remains all too common with much less justification today. But Freud’s admonitions tended in the middle of the 20th 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 patients, accompanied by a massive identification with the “aggressor” analyst.

I am very aware that in my approach five theoretical orientations or models are being utilized that directly conflict with each other and cannot
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 of listening in our receiving instrument, rather than, as we would all prefer to do, sliding back and forth between theoretically consistent or at least complementary positions. But 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. This problem in the human sciences in general is profound, and some thinkers such as Michel Foucault (10) 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.

**DIVARICATION OF CONTEMPORARY PSYCHOANALYTIC THEORIES**

My approach at the beginning of the 21st century requires tolerance and flexibility on the part of the analyst as well as a certain maturity, for it is well known that sometimes the unfortunate result of a personal psychoanalysis is that the individual becomes a strong and rigid adherent of the particular theoretical orientation and style of one’s analyst. Since there are no data available at present that convincingly and decisively prove that any of these theoretical orientations are the one and only best one, uncritical adherence to any one of them must be viewed with suspicion as unresolved counter-transference from one’s personal analysis. And these five channels are only my choices, the ones I have found most clinically useful; there are viable others.

Our beleaguered discipline is in the process of correcting itself, although I doubt this will reduce the vehemence and multiplicity of the attacks on it, which have continued since its inception. One might argue that the tyranny of mismanaged care along with the revolutionary findings of biological psychiatry have substantially reduced the incomes of most psychoanalysts and in so doing may have introduced an important initiating factor toward the revision of schismatic tendencies and the improved reality testing regarding outcomes in our field, as well as an increasing tolerance of each other’s disagreements about theoretical matters. As Benjamin Franklin said to the first Continental Congress in 1776, “We must all hang together or surely we will all hang separately.”

Wallerstein (11) emphasized the transition of psychoanalysis into worldwide theoretical diversity and the dependence of theoretical orientations on
local social and cultural factors, a fact that I have repeatedly referred to in my publications (2, 12) calling for a Nietzschean style genealogical study of what is considered “truth” and of factors influencing choice of theories among psychoanalysts in various countries. The eminent British psychoanalyst Steiner (13) also insisted, “Despite the universality of the process of the unconscious, psychoanalysis is considerably influenced by the historical, cultural, and social context in which it is developing” (p. 233). This does not mean that these overarching theoretical perspectives have equal status however, since they are not equal in ultimate explanatory power. We hope that eventually there will be greater correspondences between the constructs of the theory and the relationships between the observables in our consulting room, for psychoanalysis, as stated above, is first and foremost a medical clinical discipline (2).

Gedo (14) in a recent volume argued that the evolution of psychoanalysis can either be conceived of as the story of a discipline breaking up into irreconcilable fragments, or as the emergence of a new paradigm that transcends the disputed theories of an earlier time. This new paradigm, he repeatedly insists, is a biological or natural-science view of psychoanalysis in which all descriptions and discussions of mental functions must take into account the somatic substrate and what is known about it. As Freud said, the ego is first and foremost a body ego. Otherwise one is forced into what Gedo calls a rationalist or a mentalist view, in which various theories conflict and are not capable of being tested and being weighed. He often calls this latter stance the hermeneutic viewpoint, based on philosophical positions and with no agreed-upon standards of validation.

**CURATIVE FACTORS**

The fundamental techniques of psychoanalysis include free association, frequency, regularity, recumbency, the analyst’s general passivity, relative neutrality, abstinence, and confinement to interpretation, according to the classical view as proclaimed, for example, by Gill (15) in his earlier work. But the trouble with this formulation is that it is too simplistic; we have achieved an increasing recognition of the extreme complexity of the psychoanalytic process. Ferenczi’s elevation of the analytic relationship as a central vehicle of therapeutic change to an equal importance alongside Freud’s focus on interpretation has gained increasing acceptance in our time. The debate remains unresolved over whether the therapeutic power of psychoanalysis should be attributed to the verbal-interpretive function of the analyst or to the emotionally involved and responsive analyst asserting his analytic powers through all aspects of his or her affectively
intense relationship to the patient. We are only now beginning to under­
stand the powerful effect of the real person of the analyst, of the intensity of
his or her emotional involvement with the patient over many years, of the
special qualities that inevitably evolve in each individual’s analytic situation,
and of the use, wittingly or unwittingly, of noninterpretive interventions.
This requires the reassessment of our conceptions of analytic abstinence,
anonymity, and neutrality. There is a gradually developing consensus that
the sicker patient, who suffers from developmental pathology, requires the
 provision of support, the role of new experience, and, as Gedo (16) puts it,
the correcting of “apraxias,” defects in basic social habits of living. This
sicker group is characterized by unreliability of object contact or object
constancy; failure to tame drives or to develop stable defenses; deficiencies
in self-esteem, in frustration tolerance, and in affect modulation; and a
blurring of self and object boundaries.

In psychoanalysis the replay of old scenarios, dyadic and triadic,
including strong negative transferences, is given the greatest opportunity to
be manifested and to be successfully interpreted and worked through in the
here-and-now. One way to look at it has been presented by Arlow and
Brenner (17), who describe the psychoanalytic process as one in which
interpretations destabilize the equilibrium of forces that are in conflict in
the patient’s psyche, which leads to a growing awareness and understand­
ing of these conflicts, working through, and new conflict resolution
through more adaptive and less self-defeating compromise formations.

Yet, every good psychoanalytic clinician knows that our insights into
patients do not occur either by accident or by necessarily incisive rational
thought. The process is often more similar to what the famous contem­
porary artist Francis Bacon (18) tells us about how he gets an idea for a
painting:

What I call accident has nothing to do with some kind of inspiration with
which we have credited artists for so long. It is something which comes from
the work itself and which suddenly appears out of the blue. In the end, painting
is the result of the interaction of those accidents and the will of the artist or, if
you prefer, the interaction of the unconscious and the conscious. But you know,
things seem clear enough when you talk about them, but that’s not at all what
it’s like when you’re at the canvas. There you don’t know where you are or
where you’re going, or above all, what’s going to happen. You are in a fog. (pp.
86–87)

POSTMODERNISM AND INTERSUBJECTIVITY

This leads the discussion to postmodernism, a concept that can easily be
used as an excuse for wild analysis or relativism. But what also follows from
the postmodernist argument is that whenever a narrative appears unified, clear, and complete, something must have been suppressed in order to sustain the appearance of unity! This is extremely important for psychoanalytic clinicians to understand, because the suppressed within the story does not lose its power, it continues to affect the character of the whole. Here lies the value of deconstruction, which explores again and again the limits of the narrative in order to reveal the many unresolvable antimonies in a given narrative. This implies that any interpretation of clinical material must suppress some aspect of the material and that other interpretations are always possible. It is this situation that makes our work so extremely difficult.

From the postmodernist point of view, psychoanalysts need to listen attentively to the patient’s speech for multiple voices, not as a unified choir but to tease out singular voices that have been drowned out through years of oppression, demands for conformity and submission, and painful psychological or even physical punishment. As R. D. Laing (19) put it in his discussion of the “politics of the family,” the individual who dares to challenge the demand for conformity and submission to the family system is labeled as either bad or mad. It was Lacan’s signal contribution to call our attention once more to the patient’s speech, returning to the approach demonstrated in the early publications of Freud.

In deprivileging the analyst as the oracle of truth, postmodernism stands in contrast to the positivist interpretation of experience. It moves psychoanalysis away from the place of a scientist uncovering facts and toward the direction of a collaboration in developing personal narratives that assume the interpretive nature of all clinical understanding. The attempt to justify our interpretations as some sort of 19th-century scientific procedure actually leads to a loss of respectability, for this demeans and neglects our hermeneutic skills and real clinical therapeutic power. The presentation of psychoanalysis as a traditional 19th-century science may have been necessary for Freud to legitimate a new, highly revolutionary and brilliant discourse, but today we are in a new context, a new focus on a two-person psychology in the consulting room that creates spaces, as Winnicott (20) said, whereby two subjectivities are legitimized, each with its own history, script, and cast of characters. We are interested in the influence of one on the other, for there is no way to avoid the fact that the patient and the analyst continuously and mutually influence one another.

Furthermore, we cannot simply assume that the actual behavior of the analyst is correctly perceived by the patient, whether or not the intervention of the analyst is an accurate interpretation introduced in an empathic
and timely manner or an inadvertent error. We can only infer what any behavior or intervention by the analyst means to the patient through a disciplined study of the patient’s behavior, associations, dreams, and actions inside and outside the sessions (21). There is general agreement that the psychoanalytic treatment situation is vastly more complex than was realized by the early generations of psychoanalysts.

I have already mentioned what Gedo has called apraxias, i.e., defects in psychological ability to modulate ordinary emotional responses to the vicissitudes of everyday life. The patient brings to the analysis a certain set of maladaptive internalized practices that represent internalized identification with significant parents and/or compromise formations formed by the early ego in dealing with its three harsh masters. The patient presents these mechanisms from the very first moment of contact with the analyst, even on the telephone making the first appointment; it is sometimes possible even while setting the initial appointment to recognize patients who are paranoid, anxious, obsessive-compulsive, depressed, and so on. This is hardly totally attributable to the vicissitudes of the psychoanalyst’s input, although such input may have a triggering effect from time to time.

Our theories and our personalities always have distorting consequences on whatever appears in the analytic situation, and this is what produces the exceedingly frustrating paradox that all great conflicting theorists in our field have found clinical material in their patients that they believe validates their theories. But there are certain essential patterns that are built into the fabric of the self or, looking at it from a differing channel or theoretical viewpoint, that constitute primary ego mechanisms or defense transfers, that will be revealed sooner or later in any well-conducted analysis. However, there is no doubt that patients gain an enormous amount of knowledge about us as time passes and that it is impossible to maintain strict neutrality. At the same time, surely, it is throwing out the baby with the bath water to claim that the whole of the material of any psychoanalytic procedure is intersubjective and that the patient’s basic contribution to this material cannot be sorted out in order to stand by itself and give us at least a reliable adumbration of the patient’s psychic structures (22).

WHAT IS PSYCHOANALYSIS?

In my opinion psychoanalysis can be conceived of as a shared communal belief system subject to constant revision through clinical experience, a revision that each of us ought to be doing all of the time as a consequence of our individual clinical practice and our communications with our colleagues. We need to understand a lot more about the choice of
theoretical systems in psychoanalysis. Our basic paradigm still is the *Standard Edition of the Works of Sigmund Freud*. But what determines our choices of models? How do they affect the "data" gathered in the psychoanalytic treatment? How do they affect the psychoanalytic treatment process itself? How does one go about using more than one model in the most efficient and effective manner in our psychoanalytic work? These are questions that should be going through the mind of every analyst as he or she works with every patient.

Careful consideration of these matters leads to, at present, unresolved philosophical issues, because every theoretical orientation in turn rests on epistemological and ontological premises that conflict with each other. Here, I believe Hegel gets great credit because he left to posterity the sentiment that there is something either fundamentally wrong or at least unsublatably one-sided with our traditional ways of attaining a correct conception of reality or of finding out what things really are. This is the reason we need to take Hegel's philosophical projects seriously, as well as for the important psychological insights that are contained in his masterwork *Phenomenology of Spirit*. Here, Hegel (24) already recognizes that the self is a shifting and changing set of mental attitudes which has a developmental line of its own. His discussion of the relationship between the master and the slave is one of the best early depictions of the dynamics of the sadomasochistic interaction and is worthy of careful attention even today by clinicians. One does not have to accept Hegel's total metaphysical system in order to benefit from a study of Hegel, and for that reason in my recent book *Emotional Illness and Creativity*, (25) I have referred repeatedly to Hegel's concepts involving the function and meaning of artistic creativity and the destruction of that creativity by emotional illness.

There is a case vignette in one of Kohut's (26) books where a young male patient comes in breathlessly, stating that he drove at an incredible speed because he was late for his analytic session. Kohut simply tells him that he is crazy to do that. I might have done the same thing with this patient, simply spontaneously telling him that this was crazy behavior and he should cut it out. When one firmly tries to get the patient to stop uncontrolled and self-destructive behavior, the patient recognizes at some level that the therapist actually cares about him or her in a human way, not as a specimen being observed through a magnifying glass. I believe that this has an enormous effect on propelling therapy forward.

If a patient becomes suddenly promiscuous or begins engaging in other uncontrolled and self-destructive behavior during a psychoanalytic pro-
cess, the analyst has a certain responsibility to explore this and intervene if necessary to protect the patient. This is what I believe to be the physicianly vocation of the psychoanalyst. At least in my practice, if my patients are really doing crazy things that are dangerous and self-destructive, I intervene; from my point of view the lack of intervention represents a serious negative countertransference, as does the failure or refusal to prescribe psychopharmacologic agents during periods of acute emotional suffering that sometimes occur during psychoanalysis.

A significant number of psychoanalytic cases in the middle of the 20th century were ruined by the development of iatrogenic narcissistic phenomena because the analysts were trying so hard to be rigidly blank, neutral, and opaque. I have been told that there was one lady analyst who not only sat behind the patient, but put a screen between herself and the couch. These are very loud messages to patients about the personality and the problems of the analyst and they are bound to produce strong reactions, but such reactions are not necessarily transference.

Sometimes as a result of showing enough care to try to stop the patient from being flagrantly self-destructive, the patient pulls himself or herself together, shapes up, experiences an increased cohesion of the self, and achieves the kind of cure we often see in adolescents or young adults who have used the therapist as a temporary selfobject to shore up a self which is crumbling. Once they have done that, they do not need the therapist any more, and there is no particular reason for them to ever contact the therapist again. The only question is, can we call this a psychoanalytic cure or a nonpsychoanalytic cure? This, of course, depends on one’s theoretical orientation and beliefs as to what is and is not psychoanalysis!

Over the years I have seen a number of adolescent or young adult patients who used me in this manner, pulled themselves together, straightened out their lives, and went on to a more or less ordinary existence. They were not able to explain why this happened, and I am convinced it had more to do with the capacity of the adolescent or the young adult to utilize the therapist for whatever he or she needs at that stage of development, regardless of the theoretical orientations or interpretations that the therapist has to offer; that is to say, it is the genuineness and the personality of the therapist, as Nacht (27) says, “what the analyst is rather than what he says” (p. 106), that makes the difference [see also Nacht’s (28) discussion of this].

Switching now to the object relations channel, Summers (29) points out the great importance of Winnicott’s concept of the analytic process occur-
ring in transitional space. Summers characterizes the analytic relationship as having a

“formlessness,” the purpose of which is to provide the therapeutic space for the patient to create a new object relationship . . . the task for the patient is to find a way to use the analyst to create the needed object. The analytic object is neither the patient nor analyst but what the patient creates from what the analyst offers, an “analytic third” (p. 116).

The question of whether pregenital impulses can be analyzed and if so, how to do it, is also still debated at this turn of the century time. Anna Freud did not believe it could be done, and she opposed the so-called “widening scope” of analysis. I think the reason for this was that Anna Freud was thinking of psychoanalysis as consisting solely of interpretation, but pregenital impulses usually present themselves in archaic transferences which force the analyst to make immediate practical decisions and sometimes even to take action! I maintain that we need not be afraid of these pressured decisions if we are well analyzed and really have the patient’s best interests at heart with no secret agenda. None of us is perfect in that respect, but I do not believe that patients require perfection, in fact, thank God, they are very tolerant of our many various weaknesses and personal foibles. But basically we must have a physicianly vocation, and if we do not have it, no matter how brilliant we are, there is going to be big trouble in the analysis, or to put it in another way, we must have kind eyes. This is true even if the patient is unable to perceive those kind eyes for a long, long time because of the transference.

Why is it that in pre-oedipally damaged patients memories appear in archaic transferences and enactments rather than in dreams and verbal reports? We now know (30) there are two kinds of memories, probably stored in different parts of the brain. The important experiences that form our basic internalized object relations occur before the development of language has progressed very far, and are stored as procedural memories rather than autobiographical or declarative memories. Procedural memories involve sequences of actions and are recovered via the interpersonal situation or enactments that the patient creates in the transference-countertransference situation with the analyst. Pressures are brought on the analyst, feelings are aroused in us, conflicts disturb us internally as we work with the patient. Procedural memories antedate declarative memories and involve a network of unconscious expectations and interpersonal models. Through enactments and the exploration of fantasies, these are recovered and curative events are allowed to take place, consisting of a
modification of these expectations and interpersonal models or apraxias, sometimes via interpretation and sometimes via an inadvertent corrective experience or new object relationship formed with the analyst that neither the patient nor the analyst may necessarily know is taking place.

We can no longer adhere to a theory based on an extreme and rigid interpretation of Freud’s papers on technique, which Freud himself had sense enough to ignore when the patient’s well-being was at stake. That is why the rat-man got a sandwich from Freud’s kitchen. Can you imagine Freud as a candidate telling he did that to a mid-20th century psychoanalytic institute supervisor? John Rosen, the father of so-called “Direct Analysis” (31) used to tell this story: One day he was extremely upset at the end of an analytic session and when he got up from the analyst’s couch, the analyst beckoned to him to come into the other room in the office. There, the analyst opened a file cabinet and took out a bottle of scotch. He poured a stiff drink for each of them. After they clinked glasses and downed the whiskey, his analyst said, “Now don’t you tell anybody about this!”

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