A Disturbance in the Field

Essays in Transference-Countertransference Engagement

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Chapter 1

Introduction

The romance and melancholia of loving psychoanalysis


This is a book about transitions in clinical work. Some of the transitions are subtle, such as when a patient is able to usefully open new parts of himself in both an old and a new context. Other types of transition relate to points of impasse. Often, the transitions described relate to periods when either or both patient and analyst begin to look at a constellation of experiences or even what are traditionally termed symptoms in a different way. Needs begin to be seen as demands; self-criticism begins to be seen as related to unrealistic or perhaps even grandiose fantasies about the self; patient or analyst begins to see the ways that the analysis itself has been assaulted by unconsciously destructive trends.

I hope that I have been able to paint some pictures of the kind of atmosphere that exists between patient and analyst in relation to these moments of transition. Moreover, I try to talk about the analyst’s imagination as he tries to grasp these transitions and to help the patient to expand his imaginative capacity in integrating the meaning of transition. Despite my strong interest in the mind of the analyst and countertransference as a clinical tool, I do not want to overly valorize the countertransference. In recent years I believe that we run the risk of emphasizing too much the place of the analyst’s subjectivity in clinical work.

The “field” that I aim to illuminate is an intrapsychic and interpersonal field. I am deeply interested in unconscious conflict, unconscious fantasy, and the interpersonal process in analytic work. I cannot decide that one of these surfaces is more important than another. The analyst tries to hold these dimensions of field in his or her imagination and to make it knowable to the patient just as the patient tries to do so for the analyst.

At this point in the history of psychoanalysis, our thinking, our clinical work, and our journals are filled with the interpenetration of models. The insights offered by one analyst are used and incorporated into the vision of
another. It has taken us a while, but fortunately we have been able to begin to grow beyond a kind of institutionalized splitting.

This collection of essays reflects my version of the intrapsychic and interpersonal field. I hope that it captures a sense of how I am learning from my patients and learning about psychoanalysis.

In each chapter, I try to demonstrate my use of these various models since I am incapable of stepping back and in strictly theoretical terms to describe how I have done so. I hope that I demonstrate how the concepts of defense, conflict, state shifts, and compromise formation are essential to understanding people and how, for me, it is impossible to utilize these concepts without a two-person model.

I also try to show how we have stretched psychoanalytic concepts such as transference, countertransference, enactment, and projective identification to a kind of limit. I have no solutions to this problem in this book. I think that this book constitutes my personal stretching of these terms to their limit and my limit. What I continue to feel after 30 years of being a psychoanalyst is that there are two major frontiers that are equally important in understanding analytic process: One is unconscious conflict and fantasy, and the other is interpersonal experience and interaction. I offer this collection of essays as my best effort to illustrate how I integrate the two frontiers in my clinical work and my thinking about theory.

Our language and concepts are indeed too limited. They continually strain under the burdens of categorization and dichotomy. Terms such as negative and positive transference, negative and positive countertransference, good and bad objects, and new and old objects are as limited as the dichotomies intrinsic to drive theory, such as libidinal and aggressive. If there is anything one learns from doing analysis it is that all experience is varied and layered and holds the complexity of many things at once. Our language in psychoanalysis is still primitive and undeveloped. I wish that I could say that I have redressed this problem in this book. What I have done is try to get at and, no doubt, enact some of what Balint (1968) referred to as the “poverty of interpretation.”

It is after all rather startling that we have one word for “I” or one word for “self” despite the many meanings that these concepts entail. This speaks to the nature of our ancient and impoverished language for getting at these experiences. I suspect that future generations of analysts, particularly generations who do not grow up on the language of dichotomies, will be productive in generating new ways of thinking about analytic process.

Yet, the problems are complicated partly by the fact that we come by dichotomies quite honestly. While gender and identity are multifaceted, there are some elements of dichotomy that are probably influenced by our anatomical dichotomies. We are also either dead or alive, awake or asleep, hungry or satiated, sexually gratified or frustrated, safe or dangerous no matter how much we claim that these experiences or “facts” exist on a continuum.
In the remainder of this introduction, I would like to talk about some less-emphasized aspects of theory since theory frames and holds our language. I want to discuss less the many differences in the content of theory but rather how we each hold our theory. Perhaps this discussion will serve as a backdrop for the largely clinical chapters that follow. First, however, a note on some elements of my overarching approach to clinical work follows.

It may be useful to briefly mention some crossroads, a few intersections where theory relates to clinical work before exploring the ways that the analyst holds his theory. I want to mention briefly the limitation of the two theories that I find most useful and how other theories may help with these limitations. I value most the contributions of relational theory and contemporary Kleinian approaches, and there are also concerns that I hold toward each.

The risks and perils accompanying analysts who term themselves relational is always the valorization of the analyst’s subjectivity to the exclusion of a focus on the patient’s subjective experience. Any well disciplined, well trained, and seasoned analyst of this stripe would object to this concern by saying that we cannot know the patient’s experience except by attuning ourselves to and honoring the analyst’s subjectivity. I agree. Yet it is far too easy to dismiss the problems and hazards in this approach with this statement, just as there are considerable hazards in all approaches to psychoanalysis.

A cartoon that I came across fifteen years ago captured the essence of the problem. A man is dressed in work clothes and is speaking into the phone. The caption reads: “Enough about me, you’re the one who called 911”. The hazard of valorizing the analyst’s subjectivity is remedied by a dedication to the principle that I hold as invaluable—that analysts must devote themselves to thinking about their participation. This self-reflective process about why the analyst is feeling what he is feeling, why he is thinking or not thinking about his patient in particular ways is a way of maintaining a constant check on this hazard. I find invaluable the notion of always considering how I am being recruited to be a particular kind of object by the patient, a mode of disciplined listening that I have learned more about by reading the work of Joseph, Feldman, Steiner, and Britton as well as the work of Mitchell, Bromberg, and Davies. In my view this ability to think about recruitment is the strength, and it is a considerable one, of the contemporary Kleinian and Independent School contributions to psychoanalysis. Self–psychology always provides a useful lens on the matter of how the analyst’s use of his own subjective responses may repeat earlier forms of parental neglect or empathic failure toward the patient. Ego psychology provides a way of thinking about the patient’s shifts from affect and idea that the analyst can’t be aware of if he is too focused on his own subjective reactions, no matter how much they are also informative.

But it is in thinking about the patient’s recruitment of us as objects and our responsiveness to the patient; the patient’s internalization of our experiences and our internalized object representations; the back and forth of
this communication between internalized object worlds and interpersonal interaction; the interplay of unconscious fantasy and “reality” that I find both relational and Kleinian worlds indispensable to my work.

Relational Theory is a kind of meta-theory, an assemblage of overarching principles to approach clinical work. It does not provide a theory of technique that can be entirely separated from elements of other approaches. Instead it provides a set of working guidelines: it values disciplined listening but not necessarily a set of prescribed techniques; it considers constantly the analyst’s self-reflective participation (e.g. Mitchell, 1997); it values the dialectic between ritual and spontaneity (Hoffman, 1998), old and new objects (Cooper and Levit, 1998), nuances of interplay of patient experience and analyst’s modes of relating within interpretive positions (Benjamim, 2004); and it focuses on the ubiquity of enactment. It is why I think that relational thinking has been to varying degrees integrated and incorporated into all theoretical orientations.

The risks and perils of Kleininan theory are those that relate to the analyst’s vulnerability to minimize his own participation in enactment and the impact that his participation has on his patient. I find invaluable the Kleinian consideration that the analyst is complicit in the various ways in which he is being recruited by the patient’s internalized object world (e.g. Sandler, 1974; Feldman, 1997). But there is not enough consideration of how the patient is receiving the analyst’s participation and the ways in which enactment is constant (e.g. Mitchell, 1997; Cooper, 2008; Smith, 2000; 2008), not intermittent. The Kleinians are correct to have concerns that various elements of analyst-disclosure (ie. disclosure used to make interpretations) may enact collapses of therapeutic space or even violate boundaries in repetitive self and object patterns developed earlier in the patient’s life. So too, I agree with Caper (1997) that the analyst must have a mind of his own. But I believe that relational perspective might be very useful to Kleinian analysts in helping them to understand better a subject matter of great interest to them: the patient’s access to the analyst’s mind. In my view the patient’s internalized object relations and unconscious fantasy itself is always being influenced by the interaction with the analyst (e.g. Bonovitz, 2004; Chapter 5 in this book). Elements of relational theory provide ways of understanding a dialogic structure that can help the patient to have access and make use of the analyst’s mind, his formulations and experience (e.g. Benjamin, 2004; Davies, 2005).

**HOW DO WE HOLD OUR THEORY?**

I think that how the analyst holds his or her particular theory is at least as important as the analyst’s choice of theory. I have a strong bias toward not
letting our love of analysis or love of a particular theory become a “usurping self” (Coleridge, 1834) in the form of fixed ideas about how things are supposed to unfold in analysis. Love involves surrender and a willingness to give up or reconfigure parts of self in the service of an ideal, such as getting closer to another, protecting another, or honoring another. In analysis, surrender is related to the goal of helping someone understand himself more fully. The valorization of a theory or an idea about how analytic work is supposed to go, in contrast to surrender, involves the obliteration of another person or of self, a usurping self. The theory is a success, but the patient dies.

Even more important, I think what helps people in psychoanalysis in large degrees is the experience of knowing oneself and learning about oneself in the presence of another self. If the analyst is absorbed by his or her method and theory, too much in love with those objects, as it were, then the analyst will not have enough left over to engage with and learn from the patient. One chapter in this volume is devoted to the analyst’s countertransference to the method of psychoanalysis.

I am interested in how the analyst holds a romantic or melancholic embrace of his or her favored theory. Is the romantic version burdened by idealizations? Is the melancholic version burdened by nihilism? Is the analyst capable of holding a breadth of attitudes toward his or her theory—openness to change or a capacity to stand by this theory in difficult times?

Our relationship to theory is a particular kind of object relation. Some analysts are more monogamous with regard to their theory, while some love many. Some are more devout, while others are more “flexible” in their practice. We have particular responsibilities in relation to what theory we choose and how we practice with that theory.

I suggest two broad categories to distinguish the analyst’s relation to theory: the romantic and the melancholic. I do not use the distinction between romantic and melancholic to refer to the content of different psychoanalytic theories. For example, Strenger (1989) beautifully distinguished between romantic and classic aspects of different psychoanalytic theories. Kohut (1969) discussed varying ideological traditions implicit in Freudian theory as “guilty man,” while self-psychology was characterized as “tragic man.” Many authors, including Hoffman (1998) and Mitchell (1993), have addressed whether there are romantic versus tragic visions of human psychology emphasized in theories such as those proposed by Freud, Ferenczi, Balint, Guntrip, Loewald, and Kohut. But, my focus is much more on the analyst’s relationship to his or her own theory, not the romantic or melancholic content of the theory itself.

The romantic version of an analyst’s relationship to theory emphasizes how much the theory is helpful to the analyst in his or her understanding of the patient. It refers to the analyst’s romance with his or her theory or
theories. As a totality, the theory helps the analyst to organize disparate parts of analytic experience. It helps the analyst to explain how he finds himself thinking and working. Thus, it is an explanation that, to some extent, emanates from the sense of a natural fit. The theory also organizes the analyst’s identity as an analyst and sustains the analyst through periods of uncertainty and ambiguity intrinsic to the work. This identity for those who wish to identify themselves as a Kleinian, ego psychologist, relational or self-psychologist, also probably involves a mode of presentation to the outside world, a way to be recognized and a way that the analyst wishes not to be recognized. Many analysts prefer not to think of themselves or to be called a this or a that.

Within the more romantic dimension of the analyst’s approach to theory, the analyst may or may not idealize his or her theory. I view the idealization of one’s theory as a degraded form of relationship to theory. Idealization implies the sacrifice of individuals (patient or analyst) to concepts or principles and is anathema to the notion of disciplined experimentation and growth that are at the heart of productive analytic work. The analyst’s idealization of a theory is also fundamentally solipsistic, not “relational.” Idealization of theory is dehumanizing since, in Adorno’s (1950) terms, the human is degraded and subjugated to fallibility unless it serves to prove the tenets of the theory. Idealization truck only with humans who fulfill its predictions and descriptions of how things are supposed to go. Rarely does it truck with understanding patients.

A melancholic position emphasizes that every theory is a theory waiting to be rendered limited or problematic by clinical work with a particular patient. Melancholic positions make the analyst lean toward a more pragmatic approach to theory. It may also make the analyst lean toward a pluralistic openness, a willingness to utilize a variety of theories in helping us to understand clinical work. Melancholic positions allow the analyst to make vigorous use of one theory with a particular patient with a sense that it may prove to be limited in its helpfulness in analytic work with another patient.

The melancholic position also provides a vantage point from which to consider or at least acknowledge that to some extent there is a kind of manic phase in the development of each new psychoanalytic theory. Each theory arises in the context of solving a problem or limitation posed by a previous theory—Klein’s response to the undeveloped object relations dimension of Freudian theory; Ferenczi’s and his descendant’s (e.g., Balint, Guntrip, Fairbairn, and American relational theory) response to Freud’s more limited focus on the neuroses; the development of ego psychology as an elaboration of the importance of ego functions and the yet-to-be-developed elements of defense analysis in Freudian theory; the failure to take into account a healthy narcissistic developmental line in Freudian
theory elaborated by self-psychology; and the failure of much of early psychoanalytic theory to account for the person of the analyst addressed by interpersonal and relational theory. Each of these new theories represents an attempt to redress limitations in previous theories.

The degraded version of the melancholic relation to theory is a kind of theoretical nihilism. This is not a healthy, functional use of pluralism but rather a despairing one. In this version, no theory is really good enough for very long, and we move from theory to theory when we reach the limitations of each theory. In this type of object relation to theory, essentially the analyst is unable to be held and framed by a particular theory. The analyst is theoretically parentless and somewhat privately self-sufficient. The analyst wanders from theoretical home to theoretical home. He or she is lonely.

Martin Cooperman, a beloved teacher for many years at Austen Riggs, had this comment attributed to him: “The patient comes to analysis with symptoms and the analyst comes to analysis with a theory. If things go well they each give up what they initially brought to analysis.” I think that a part of what Cooperman meant is that no theory can “understand” a unique person. Each theory is too general, too much a composite of observations gleaned from many patients—a kind of affective and ideational summary or average of working with many patients. And, each theory represents a more distant perch than the way that patient and analyst come to know each other. Cooperman’s statement is a good example of the melancholic relationship to theory. It reminds me of the way that Winnicott and Lacan in different ways spoke of the analyst’s willingness to be used and discarded by the patient, not unlike the good enough parent.

I view Cooperman’s position as distinct from those that claim not to use theory. I do not believe that there is such a thing as not using theory; a more productive way to frame the question involves the degree to which the analyst is aware of his or her theory and the ideals and ideas that direct the analyst’s decision making.

I have been strongly influenced and continue to be influenced by strands of Freudian, Kleinian, self-psychological theory, and in the last 20 years relational theory. My relationship to theory is decidedly melancholic. I use a variety of theories to help me understand my patient and the limits of my approach. I like to think about the value in standing outside our theory and trying to think about clinical work in various ways. I use the term the pluralistic third to help describe how I work with various theories to investigate some the decisions that I make. Each theory requires of the analyst a level of personal responsibility related to thinking about what the analyst is seeing and not seeing from the analyst’s particular vantage point. Put another way, this questioning is a way to “love” and make use of one’s theory rather than idealize it.
FALLING IN LOVE AND BEING IN LOVE WITH PSYCHOANALYSIS

I make distinctions between wholesale idealizations of theory and theorists versus ways that analysts, as very specific individuals, make use of theory and parts of theory. Sometimes, falling in love involves varieties of idealization and a wish to more fully embrace another, even at times to sustain the illusion of merger with another. Sometimes analysts, often young analysts, merge with their theory, and it is only over time that they undergo elements of deidealization and disillusionment that yield to their own particular and partial ways of embracing and discarding theory.

When I was introduced to psychoanalysis, I fell in love in some very specific ways. At a personal level, I found psychoanalytic treatment very helpful when I was a young man. I also identified with my analyst, and this was crucial in terms of my decision to become a psychologist and later a psychoanalyst, particularly since I studied philosophy and literature prior to graduate studies. As a late teenager, I read some Freudian texts with much of the same zeal and enthusiasm that I read Nietzsche and Marx. These were “total institutional” (Goffman, 1961) systems that appealed partly because I was looking for comprehensive explanations.

While I was first studying about psychoanalysis before I received “formal analytic training,” I also was introduced to several teachers whom I admired greatly. Each introduced me to a new body of ideas, and in his own way, each lived and breathed psychoanalysis. It was also an opportunity to learn psychoanalysis from outside an institution that, in retrospect, I feel fortunate to have learned before receiving formal training.

On balance, I would say that I fell in love with psychoanalysis, “hard.” Some people who become analysts come to it slowly, over time, thoughtfully or with caution as they learn more about it. I was smitten from the get-go and found myself idealizing analysis and a variety of analytic theories. My love has been an enduring love as it undergoes change, disillusionment, new appreciation, and new questions—but enough about me.

Our relationship to falling in love with psychoanalysis versus loving psychoanalysis is crucial to understanding the analyst’s relationship to his or her work with patients, technical choices, relation to personal theory, and method in general. I suggest that falling in love is often best seen in terms of an idealization that provides blind spots even as it helps the analyst to organize experience and build a psychoanalytic identity. In contrast, loving psychoanalysis includes the degree to which we accept the limitations of psychoanalysis and our own theoretical orientation. It includes the degree to which we are willing to integrate disciplined experimentation into our method versus embracing more wholeheartedly what we have been taught.

For example, when I was first beginning to be interested in psychoanalysis, one of my first teachers was Merton Gill, who had been developing
some of his ideas about the early interpretation of transference. I was a true believer in the merit of his arguments and found it helpful with a number of my new patients. Yet over time, I found that in working with some of my patients it was less helpful, at times disruptive to our process of working together. This allowed me also to develop a more nuanced and sophisticated application of Gill’s ideas to all of my patients, and I learned about how I disagreed with some of his ideas about the theory of technique. I had gone from falling in love with his methodology and its accompanying idealization to a more functional deidealization, which in turn made it easier to make use of his work in my work.

Our loving feelings toward psychoanalysis provide a new angle on the much-maligned concept of neutrality. Many have elaborated the degree to which neutrality is an abstract ideal more than an absolute, achievable interpretive position. One of the complexities related to the neutrality concept relates to how our investment in our method is a part of our self-interest. Being in love with psychoanalysis may sometimes create difficulty for analysts in deeply integrating the limitations in our method. In fact, for some analysts it probably sounds like therapeutic nihilism even to refer to the concept of limitation (Cooper, 2000b). Our investment or passion in theory always has an impact on the kinds of neutrality that we are able to achieve.

I suppose this takes me full circle to a way to appreciate anew Freud’s concept of therapeutic modesty and to integrate it with the notion of a melancholic approach to theory. While Freud was in love with psychoanalysis and his developing ideas that gave birth to psychoanalysis, he struggled repeatedly not to let his being in love influence the development of his theory. (See Parsons, 2006 for an extensive discussion of this matter.)

Freud’s treatment of Herr E provides an interesting snapshot into his struggle to manage his feelings of being in love with psychoanalysis while trying to investigate and develop his method. To some degree, Freud seemed to be struggling with being in love with his theory to the point that he was also aware of his wishes for Herr E to be an extension of his theory. Freud was quite happy about the progress that his patient was making and the degree to which Herr E’s progress confirmed some of his technical and theoretical principles. He wrote to Fliess as the treatment began:

You can imagine how important this one continuing patient has become to me. … Buried deep beneath all his phantasies we found a scene from his primal period before twenty-two months which meets all requirements. … I can hardly bring myself to believe it yet. It is as if Schliemann had dug up another Troy which had hitherto been believed to be mythical. Also the fellow is feeling shamelessly well. He has demonstrated the truth of my theories in my own person, for with a surprising turn in his analysis he provided me with the solution of my railway phobia. (1954, pp. 305–306)
Only 3 months later, Freud’s excitement about Herr E’s progress and its implications for his theory development had decidedly changed, giving rise to a major innovation in his theory of technique:

Prospects seemed most favorable in E’s case and it was there that I had the heaviest blow. Just when I thought I had the solution it eluded my grasp, and I was confronted with the necessity of turning everything upside down and putting it together again afresh, losing in the process all the hypotheses that until then had seemed plausible. I could not stand up to the depression of all this. I soon found that it was impossible to continue the really difficult work in the face of depressions and lurking doubts. When I am not cheerful and master of myself every single one of my patients is a tormenting spirit to me. I really thought I should have to give in. I adopted the expedient of renouncing working by conscious thought, so as to grope my way further into the riddles only by blind touch. Since I started this I have been doing my work, perhaps more skillfully than before, but I do not really know what I am doing. (1954, pp. 311–312)

This letter to Fliess shows us much about the origins of Freud’s technique related to free-floating attention. But, it also tells us something about his ability, indeed necessity, to modify and change his theory as he learned about doing clinical analysis. In this letter, there is the essence of the capacity for a melancholic position in relation to theory. Freud’s despair was intense about the need to reject his theory but not so despairing that he was unable to surrender to a new way of thinking and learning about the nature of his developing understanding of psychoanalytic process. It gave birth to a revolutionary technical discovery to let the analyst be adrift in his associations.

Canestri (2006) and Fonagy (2006) have each usefully emphasized the importance of moving from clinical practice to theory. Innovations in technique do not generally come from theory, they lead to new theory. I regard Canestri’s position to theory as decidedly metabolic.

I have previously argued that, for all analysts, “facts all come with a point of view.” Freud wanted his patient, Herr E, to demonstrate that his beginning ideas about technique and therapeutic action were correct, and to the extent that they were not, he became distraught at times and hopeless. While Freud was the progenitor of our method, I do not think that any analyst is immune from the problem with which Freud struggled with Herr E. To some extent we love the theories we choose because they are a part of us. I believe that our theoretical choices are embedded in our body experience (e.g., Cooper, 1996), so when our patients disprove our theories, we take it quite personally whether we want to or not.
Loving one’s preferred theory in analytic work needs to be tempered with an ability to see the blind spots in one’s theory. This is where the analyst’s theoretical choice and personal responsibility comes into play. Facts not only come with a point of view, but also each fact has new and original meaning waiting to be discovered (Ferro, 2004) unless it is, as Coleridge put it, “a fixed idea” that tells us who we are rather than letting us be who we are in relation to clinical facts.

I have heard some patients complain that their analyst (sometimes me) loves his or her technique more than the patient. To some extent, of course, this is an epic battle for many a patient as the patient tries to get the analyst to love him or her, while the analyst’s job is to understand the patient and show the patient how to understand him- or herself (Freud, 1912). However, there is something to the idea that if the analyst is also in love with his or her method it can become an obstruction for analytic work in at least a few ways. Each theory is vulnerable to the criticism: “The operation was a success, but the patient died.” I agree with Slavin and Kriegman (1998) that the analyst needs to change, although I think that this is a concept that has unfortunately been misunderstood and oversimplified. Analysts change with their patients because they are learning more about who the patient is and how they are implicated through the countertransference link. In some way, each analyst must surrender to the patient just as the analyst analyzes the patient’s method of self-cure (Chasseguet-Smirgel, 1985; Kahn, 1970) that interferes with the patient giving up old, ineffective solutions to problems, conflict resolution, and the integration of various affective states and experiences. In a sense, the notion of the analyst as a new object also includes the fact that the analyst has to become a new object to himself. Each analyst becomes a new object in a different way with each patient.

Falling in love with an ideology, theory, or method is intrinsically at odds with being a good psychoanalyst in a way that Cooperman’s quotation in this chapter addressed. In a sense, we use our theory or method to learn enough with our patient to shed our theory in a unique interpersonal context with each patient. This is a love that is based more on who the real person of the patient and the real person of the analyst are, not who they are expected to be in accordance with a theory.

This argument is at odds with those analysts who idealize clinical work in such a way that makes them reject theory or even claim that they do not use theory. I am highly suspicious of such arguments. If we listen to the work of any analyst who claims that he does not have a theory or a theory of therapeutic action, what is revealed are implicit protean forms of unarticulated theoretical influences, theory particles if you will, that are disavowed but still influential. I always listen to the clinical material presented by another analyst with the aim of trying to deconstruct the implicit or explicit model that seems to inform the decisions that the analyst makes whether he or she lays claim to working with theory or not.
This mode of “not using theory” is in fact a form of being in love with psychoanalysis as an idealized idea about analysis more than a practice of self-reflective participation. It is a love that degrades and minimizes the theoretical holding environment that partly influences his decisions.

Many young analysts fall in love with psychoanalysis in ways that relate to the help that they have received in their personal analyses. This love is one that will never disappear, but it will likely change. Over time, they will see the limitations in their own analysis and in analysis in general. They will get to know more fully the illusion intrinsic to any other form of falling in love.

Perhaps psychoanalysis has taken enough of a fall as an institution that it is less likely now than in years past to encounter people in training who are in some ways looking for something to idealize. In days past, some aspects of analytic training would reinforce elements of idealization and mystification about becoming an analyst. Students today are much more sophisticated about the substantial amount of criticism that has been levied against psychoanalysis from various corners, including disaffected analysts and patients. I suggest that the students of today are in a better position than earlier generations were to learn about psychoanalysis. While the position may be more melancholic, it may be more suited to these students becoming talented psychoanalysts.

THE PLURALISTIC THIRD

Different clinical theories valorize particular aspects of clinical understanding. I try to hold myself accountable through thinking about the blind spots consequent to prizing the particular lenses that I trust most. I use a concept that I call the pluralistic third (Cooper, 2007b) to think about clinical work from a variety of perspectives. I hope that in the clinical examples in this book I demonstrate how I make use of such a concept.

The pluralistic third means, somewhat counterintuitively, that there is value in thinking critically about our decisions from perspectives other than the one we initially used. While this can be harsh, and often has been in somewhat destructive conversations involving comparative psychoanalysis, I hold a great deal of hope that there can be value in thinking critically about our decisions using the pluralistic third—to provide a third to the dyadic relationship the analyst holds to his or her own theory and its limitation with a particular patient. To some extent, this can be a bit of a rigged experiment because few of us ever use only one model. Thus, I may in fact be using elements of inquiry about what I have done that are already a part of how I work. Furthermore, various psychoanalytic theories have interpenetrated one another in ways that can sometimes make it difficult to tell whether there is more disagreement between analysts within the same orientation versus analysts from different orientations (Cooper, 1996; Smith, 2003; Teicholz, 2006).
My working ideal about clinical information and process is related to what Ronald Britton (1998) refers to as “vulnerable knowledge.” It is always the case that we are working with ambiguity about “clinical facts” (Ferro, 2005). Sometimes, the pluralistic third may help us to think about this ambiguity.

The rationale for this approach relates to how, given that we have an unconscious attachment to our theory, it is axiomatic that we have intrinsic blind spots as well. Just as a hologram is created through the interference of light from separate sources, so the pluralistic third can sometimes allow for a different perspective on the blind spots. Bion (1963) referred to these blind spots in the clinical encounter with two terms: “selective fact” and “overvalued idea.” Both concepts involve the degree to which we can sometimes be prone to rely too much on our initial formulations to make sense of things. These tendencies to listen with selective focus are also manifested in theory building and the application of theory.

Selected facts stand in contrast to what Britton (1998) calls vulnerable knowledge. Britton is trying to elaborate how our tendency to be influenced by unconscious factors is embedded within our vigorous efforts to claim total rationality in our belief systems.

I am interested in how our countertransference to our own theory or ideology keeps us from benefiting from vulnerable knowledge. Stepping outside our theory is from my point of view more consistent with an adaptive melancholic position involving deidealizing our theory and the mourning of the lost idealization. It allows for the idea that our beliefs may sometimes be misapplied, in part defensively determined and thus selectively perceived.

For example, each theory is reliant on a particular valorization of illusory analytic play space—the selfobject function in self-psychology; the drive derivative in close process ego psychology; dyadic/interpersonal reality, the analyst’s subjectivity, and the concept of enactment within relational theory; and for the Kleinians, unconscious fantasy, the transition from paranoid to depressive position, as well as a very specifically defined use of countertransference. I wish to develop useful and sympathetic, although external, models of questioning these constructs of illusory space that are specific to each approach. (For example, Freud implicitly addressed the illusory space in drive theory when he defined drive as a mythological/metaphorical frontier between psyche and soma.)

Developing ways of questioning our work neither requires nor recommends that we as analysts relinquish our theoretical preferences and reliance on particular kinds of illusory analytic constructs. It would be extraordinarily naive to think of our allegiance to a model as so easily prone to persuasion. Our allegiance to a theory is based in deeply personal and bodily attachments and, as well, to what has been therapeutic or growth producing with parents and analysts. To use a developmental analogy, what I am suggesting is that we approach our preferences and
the pluralistic realm of theory more like that of a post-oedipal child—with healthy doses of both love toward our theoretical predilections (helpful, guiding, and well-intentioned parents) and skepticism.

It is also important to note that the concept of the pluralistic third could be translated crudely to mean that we, the analysts, should always be questioning our decisions and interpretive directions from various perspectives. Nothing could be more inaccurate. A translation of that sort sounds like it might create a highly obsessive and intellectualized analyst, perhaps an analyst with a kind of theoretical obsessive-compulsive disorder (TOCD) who is in effect trying to leave no theoretical “stone unturned.” Instead, the concept is offered as a mode of reflective function, carried out by the analyst at particular times when the analyst is thinking about his work or, especially, thinking about moments of impasse or slower growth in the analytic work.

**A MELANCHOLIC APPROACH TO PSYCHOANALYTIC THEORY**

Briefly, I take a problem in the history of the development of relational theory to demonstrate some of the concepts that I refer to in thinking about the pluralistic third and the melancholia of theory.

There are many ways of thinking about dimensions of self-reflection and accountability in a relational model, and the task is a formidable one. First, the word *accountability* is an evocative one, with all of its evaluative and potentially punitive reverberations. Second, there is no one relational model, so particular ways of working need be defined to be assessed. For example, I know that some theorists who call themselves relational might tend to think of my interest in conflict as always better described by concepts such as self-state shifts.

I don’t think of a relational theory as a theory of technique. I think of it as a guiding set of principles that have accompanied an integration of Freudian, interpersonal, self-psychological, and independent tradition schools of psychoanalysis. It includes a set of foundation principles—principles such as the dialogic nature of psychic meaning; the value of countertransference experience in understanding the patient’s internalized world; and an ethic of disciplined experimentation.

If I were going to break down the matter of how one holds oneself accountable within a relational model, I would ask questions such as the following: How does the analyst continually look at enactment in the immediate context and over time? How do we decide about the tensions between restraint and expressiveness? In particular, how do we decide to use elements of our disjunctive subjectivity from that of our patient? In abandoning more linear models of development, how do we evaluate the patient’s experience and associations as emanating from regressive or progressive vistas?
Many changes in technique and theory have been established as a part of relationally oriented analysis, raising questions about how to evaluate the work and how to hold the analyst accountable. How do we determine which enactments are inevitable and which might be unusual in terms of being deeply embedded in particular aspects of the dynamic makeup of the analyst? What are the guiding principles that dictate various aspects of the analyst’s countertransference expressiveness? When is it the case that analyst and patient in a relational model get caught up in dyadic realities without the helpful or requisite presence of the third? Since some of the most interesting and influential articles from the relational tradition address moments of impasse, what are the applications to relational theory to exploring more routine moments of analytic work? For example, what is the place of the analysis of defensive vicissitudes within a relational model, and when does the analyst’s attention seem to focus more exclusively on these defensive vicissitudes?

One of the most interesting debates within relational psychoanalysis involves what guides the analyst’s decisions to utilize aspects of his subjectivity and when to do so. In an interesting article, Slochower (1996) discusses how she works with some patients for whom the sharing of the analyst’s subjectivity in the formation of interpretations creates a toxic reaction to knowing the analyst. Steiner (1993) has written about this dilemma from a contemporary Kleinian perspective as well. In these instances, the patient is said to not yet be able to stand a mutual analytic experience. During what Slochower regards as a kind of analytic “holding,” the patient experiences an illusion of analytic attunement, requiring of the analyst a containment of his or her disjunctive subjectivity, not an abandonment of his or her subjectivity. In fact, Steiner refers to patients for whom even an interpretation that takes into account what the patient might be feeling about the analyst is an assault. Slochower argues that for patients for whom externality is equated with either abandonment or rupture, the movement toward mutuality will require that the analyst begin to fail in ways that increasingly expose the patient to his externality and thus his subjectivity to the patient.

Slochower (1996) essentially argues, as a relational analyst, that there are patients for whom knowing the analyst’s subjectivity (e.g., interpretations that integrate aspects of the analyst’s experience) requires of them to be pseudomature adults. One scenario, among many, is that a false self can develop in which the patient obscures aspects of painful encroachment or the false self falters and the individual becomes more blatantly derailed. For Slochower, holding involves a situation in which the patient cannot challenge or is less likely to challenge the boundaries of the analytic holding experience. Instead, patient and analyst implicitly agree not to question the analyst’s largely good intentions, emotional resilience and reliability, or capacity to hold for some periods of time during analysis.
In a critical essay discussing Slochower’s (1996) article, Bass (1996) suggests that Slochower might tend to bring to the analytic situation the notion that her subjectivity connotes aspects of unreliability and a lack of safety. Bass proposes that attempting to elude or obscure rather than to explore the ways that the patient may find his safety compromised through the analyst’s presence tends to increase rather than resolve whatever difficulties are posed by the analyst’s presence and interventions. Bass would suggest that this type of holding involves a degree of sleight of hand in which the analyst’s subjective presence is seen as likely to contaminate or interfere with the analytic process in contrast to a relational approach that emphasizes the “inevitable, ubiquitous and potentially constructive presence and impact of the analyst’s personal self” (p. 367).

Finally, Slochower (1996) counterargues that there is no one-sided sleight of hand on the part of the analyst within the holding that she describes. Instead, holding describes the coconstruction by analyst and patient of an illusion of analytic attunement in a way that temporarily puts into the background certain disjunctive aspects of the both parties’ experience that will later give way to the interpretive work for which she eventually aims.

As you can see, even within the group of analysts who think of themselves as “relational,” there are differences in how they define intersubjectivity, mutuality, and holding within the analytic process, and this is but one of the several interesting debates within relational theory. (In general, the treatment of idealizing transferences is a point of fascinating debate among analysts; e.g., Hoffman, 1994; Renik, 1995.)

So, what kinds of conclusions can we draw from these differences? At the least, the criteria for accountability that Slochower (1996) would demand of herself would likely be quite different than those used by Bass (1996).

While the point of the pluralistic third concept is to suggest how we might think about our work using outside models, the differences from within the same orientation seem equally important, as is suggested through the interesting debate between Slochower (1996) and Bass (1996). For example, it seems to me that an analyst who is sensitive to the kinds of issues that Slochower has elaborated so beautifully would do well to consider the warnings by Bass that the determination about a patient’s sensitivity can involve assumptions overdetermined by countertransference predilections. Similarly, Bass’s ambition regarding taking up the potentially disruptive impact that his subjectivity will have on the patient may be tempered by considering Slochower’s emphasis (relationally oriented versions of Kohut’s, 1969, and Steiner’s, 1993, descriptions of the same phenomena) on some patients’ limitations to absorb elements of the analyst’s subjectivity. Any analyst of any persuasion is capable of using sleight of hand in his position as analyst.
I do not resolve questions such as these through thinking about theory, and I would not be able to say that I agree with one of these analysts more than the other in terms of how I work without having a particular patient in mind. I have felt the constraints and inhibitions that Slochower (1996) highlighted and the freedom in the face of constraint that Bass (1996) suggested is possible. I have also felt the inability for the interpretive freedom that Bass suggested. At these times, the technical suggestions Slochower made are helpful. What I am suggesting is not a solution to a debate such as this except through the value of having these quite different ways of thinking about patients available to us. Many of these kinds of theoretical debates are resolved in the ethical and clinical imagination of the analyst.

This imaginative capacity of the analyst is what I would suggest is a kind of posttribal approach to psychoanalytic theory. The reason for teaching our students a variety of theoretical traditions and contributions from a diverse group of analysts is so that their clinical imaginations will be as free as possible to work with their patients.

My favorite expression in Freud’s (1920) writing, from The Ego and the Id, is the description of the ego as a frontier creature existing between the internal and external world. I like the notion of thinking about the analyst as a frontier creature also since he lives in the patient’s and the analyst’s sense of reality, moving back and forth as the analyst helps the patient to dismantle and reconfigure parts of his psychic world. Each of us relies on our orientation and in doing so partly becomes a tamed creature, tamed by his own need for familiarity in the face of this difficult task. By stepping outside our own way of looking, we can sometimes jolt ourselves for potentially useful moments, claiming a new frontier. In parallel to the patient, we dismantle our own settlements and scaffolding. It is just one of the many forms of what Ghent (1990) referred to as “surrender.”

This process helps us to engage in the mandate and sometimes folly of facing the intrinsic limitations, fallout, and collateral damage of whatever approach we most value, a melancholic paradox if ever there was one. It is something we do with those and that which we love. It is a part of what I love about psychoanalysis.