Memory, Myth, and Seduction

Unconscious Fantasy and the Interpretive Process

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Chapter 3

Intersubjectivity and the analytic relationship*

In the 1926 Encyclopedia Britannica, Freud stated that the term psychoanalysis came to have two meanings: “1) a particular method of treating nervous disorders”; and “2) the science of unconscious mental processes, which has also been appropriately described as ‘depth psychology’” (p. 265). In the last 35 years or so, psychoanalysis has become primarily a clinical and therapeutic technique; elaborations of the concept of the unconscious and a theory of mind have become increasingly secondary, if not irrelevant. The majority of contemporary, particularly American, writings deal chiefly with clinical technique and the interactive aspects of the psychoanalytic situation. And, within these topics, there has been an increasing emphasis on the role and experiences of the psychoanalyst, whose mental processes, once unduly neglected, have almost taken center stage.

We hear much of psychoanalysis as a healing relationship, meeting some presumed primary relational needs. This focus on the relational, interactive (subjective, dyadic, intersubjective) aspects of psychoanalysis is shared by many authors, expressing a wide range of approaches. I cannot here review this broad literature and do justice to its variety and complexity. Furthermore, many of these authors are difficult to evaluate because they are often quite ambiguous about how much they reject the traditional goals and rationale of psychoanalytic treatment, and they are as well rather vague and inconsistent in translating their arguments into actual clinical practice.

I shall discuss first the challenge to the ideal of the objective, neutral, and anonymous analyst, as expressed most forcefully by Renik (1992, 1993, 1995, 1996). I will then briefly examine Ogden’s (1979, 1994) use of the concepts of intersubjectivity and projective identification. At the end, I shall touch upon some general issues about the nature and rationale of the analytic relationship.

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RESPONDING TO RENIK

Renik has an easy time attacking the rather caricatured picture of the analyst as the lofty embodiment of reason and objective reality, overcoming the patient’s resistances and subjective distortions. Such a picture has some reality in the writings of Freud, Klein, and many others, although we know that Freud and Klein were far from impersonal in their actual attitudes toward patients. But it has become clear that the analyst’s specific theory, what Schafer (1992) calls his master narrative, predetermines his answers to most basic questions. Renik was hardly the first to point this out. The issue was already raised just about 100 years ago by the 4-year-old Little Hans: “Does the professor speak to God, as he can tell all beforehand?” (Freud, 1909b, pp. 42–43). We don’t speak to God, and we hardly speak to Freud anymore!

Complete neutrality and anonymity have always been impossible, if even desirable. Every intervention of the analyst is an expression of his point of view, his theory, his rationale and goals of treatment, as filtered through his own style and personality. In that sense, his interpretation is always relative, subjective, and changeable. Renik’s arguments are clearly valid, if fairly obvious.

In a narrow sense, Renik can be seen as advocating a change in the analyst’s attitude and manner, essentially a corrective to some of the excesses of the past. I am referring to the times when some analysts believed that to be silent most of the time and never to answer a question or even a greeting was to be neutral and anonymous. Instead, it probably made them appear stilted, pompous, and uncaring rather than neutral. Quite a few older analysts were subjected to this form of anonymous neutrality in their own analyses and maybe are getting even now. So we may know better now and try to be more natural, open minded, and willing to have some dialogue with our patients.

But Renik (1996) goes much further than pointing out the limitations of neutrality and anonymity. He tends to claim that because complete neutrality and anonymity are impossible, there is no point in trying to maintain them at all and he further indicates why the “pursuit of neutrality as a technical ideal is counterproductive” (p. 497). Yet there is obviously a wide range in the use of personal self-disclosure and the amount of suggestion and explicit guidance toward specific goals and values. And much of this does remain under our conscious control. Such control is facilitated, although by no means ensured, by features of the setting and frame (lack of face-to-face interaction, avoidance of outside session contacts, etc.).

The patient does get to know his analyst firsthand, but rather, primarily if not exclusively, as functioning as an analyst in a special setting, what Schafer has called the “analytic self,” endowed by the setting and his training with all sorts of qualities—tolerance, forbearance, clear vision—which
may not be conspicuous in the rest of his life. Of course, this analytic self, especially at a more unconscious level, is bound to reflect extra-analytic aspects of the analyst’s personality; but it also has a large degree of autonomy. And what the patient knows about the “real” analyst beyond the sessions usually consists of small isolated bits of information, serving as fodder for transferential fantasies.

It shouldn’t need restating—but it obviously does by now—that the attempt to maintain some neutrality, boundaries, and objectivity is an intrinsic feature of the psychoanalytic situation. It is essential not only for the interpretation of transference, but also to protect the patient from undueindoctrination and from what may be considered the intrusive interference of irrelevant aspects of the analyst’s personality. That this protection is never complete and that it is hard to draw a line between what influence is helpful and what is distracting and intrusive do not make the goal of neutrality unnecessary and impossible.

I think that under the so-called rule of abstinence, the analyst may need to withhold undue gratifications from himself even more than from the patient. For the analyst, self-control, self-discipline, and tolerance for frustration are required at all times, even if lapses are unavoidable. It is hard for me to conceive of a situation which would still resemble analysis if the analyst freely gives advice, makes moral judgments and teachings, and is ever ready to talk about himself, offering his own experiences as examples or models for the patient.

This is what Renik seems to endorse, if not advocate, although he is more ambiguous when it comes to specifics. Thus, after having recommended the rejection of anonymity, he gives as an example of free self-disclosure: sharing with the patient the reasons underlying his thoughts and interpretations in a specific context. I think many of us, myself included, have been doing this frequently, without needing to invoke a change of technique or theory. And, at times, Renik admits that the analyst’s self-disclosure should be “selective” and subordinated to the goal of increasing the patient’s self-awareness.

With the postmodern emphasis on the relativity of analytic theories and analytic knowledge, any dogmatic, inflexible position has become harder to justify and rationalize, if it ever were justifiable. Analysts are also influenced by a social climate where any open display of an authoritative attitude has become unpopular. This, in general, may have more to do with the display style of authority and power than with their actual use, and a premium is put on appearing sincere, spontaneous, warm, and so on. In this context, Renik (1995) and many others see the optimal analytic interaction as a “collaboration between peers” (p. 492) exchanging opinions on an equal footing and comparing freely their separate experiences of the interaction.

This may sound appealing, but I think it is rather unrealistic and deceptive, given the nature of the analytic situation. For nobody actually denies
that this situation is uneven and asymmetrical, with the two participants in very different roles. The interaction is supposed to be centered around the patient and his psychological reality, particularly in its unconscious aspects. If the psychoanalytic interaction allowed the analyst equal opportunity to express his personal concerns and interests, to take turns free associating, it could easily become an exploitation of the patient, psychologically and practically. Nobody has yet suggested that, for the sake of equality and mutuality, the two participants alternate in paying the bill.

But one should be reminded that asymmetry need not mean that the analyst becomes the authority and the repository of truths to which the patient must eventually acquiesce. The situation is not an adversarial legal court battle as to whose version of the facts will be accepted (this seems to be the model which Gill and Hoffman, 1982, assume and then try to repudiate so forcefully). It is precisely the analyst’s role and position in an asymmetrical and structured interaction that allows him not to see the truth, but to contribute a different perspective, possibly more broad, objective, and detached than the more direct, intense, and narrowly centered experience of the patient.

However, it is not a process of the analyst’s supposed superior knowledge or wisdom superseding the patient’s self-deception and ignorance. An interpretation does not basically challenge or disown the patient’s experience as mere manifest content (the “real” meaning of a is b). Rather, it points to some connections and patterns, which were missing or only background for the patient, and suggests additional and alternate meanings to the patient’s experience—expanding rather than negating and superseding it. How the analyst handles the authority given to him by the transference and how he uses it and/or challenges it remains, of course, a major issue.

More generally, as Friedman (1996) has remarked, the believers in an open collaborative relationship are not without their own predetermined ideas of what the treatment should be and their own, at least implicit, theory of pathology and development. And dogmatism or arrogance is not the attribute of any theory, relational or other, but of individuals.

The seeming respect for the patient’s equality and autonomy can sometimes lead in the opposite direction; for instance, Hoffman argues that because we are bound to influence our patients in ways which we cannot control, we might as well express our opinions firmly and directly and exercise explicit influence. Does he believe that this will diminish our covert influence?

So with Renik, what seems at first a mere correction of past distortions of the analytic attitude is really more than that, even more than a change in technique, as Renik claims. It amounts to a change in the rationale of treatment and the understanding of psychopathology—what some authors have somewhat grandly labeled a paradigm shift. While Renik (1995) tries to remain within a classical model, he does state the main conclusion quite clearly: “If an analyst places primary emphasis on the importance of healing
interactions within the treatment relationship, as opposed to the pursuit of insight, there is no reason for the analyst to strive for a posture of anonymity” (p. 475). Indeed, that would be undesirable and interfere with the goal of generating new experiences, presumably as intense, spontaneous, and authentic as possible, with a new object.

Renik (1993) states that there is nothing wrong with the analyst enacting personal motives, such as a wish to compete with or punish a patient—although his actual example is very mild and hardly objectionable—as long as the patient is given a chance to explore his reactions to such behavior (p. 563). I suspect that such a position is likely to discourage a disciplined reflective attitude in the analyst and legitimize the most immediate subjective reactions, gut feelings, and such in the name of spontaneity and “authentic candor” (1995, p. 493).

Renik’s (1993) analogies between the experience of the analyst and surfing, skiing, or good sex as situations where one “allows himself or herself to be acted upon by powerful forces, knowing that they are to be managed and harnessed, rather than completely controlled” (p. 570) may sound appealing to many, but can make one wonder about the limits and aims of an analyst’s behavior. So does his recommendation to be “passionately and irrationally involved in our everyday clinical work” (p. 570). Renik even writes:

It is the ethical norms we establish…rather than our theories that prevent us from taking advantage of our patients. We do not have sex with our patients or borrow money from them for the same reasons that internists and surgeons refrain from doing these things with their patients (because responsible care givers do not want to trade on the hopes and fears of people who rely upon them), not because we conceptualize that enactment of fantasies interferes with the analysis of transference. (p. 566)

I would suggest that it is for both reasons. The engagement in certain behaviors precludes any constructive analysis of them. Renik is fully aware of the need for the analyst to avoid a self-indulgent exploitation of the analytic situation; however, one could certainly wonder whether his recommendations do not increase the danger of such an exploitation and can even provide a rationalization for it.

For Renik implicitly and for many authors explicitly, the basic model seems to have become that of psychoanalysis as a healing relationship. Then one must ask: What kind of a relationship? What does it heal and how? These are basic and familiar questions which I will briefly touch upon in the last part of my discussion. I think the term “relationship,” unless further specified as to type and purpose, has little meaning except as a kind of buzzword or partisan label. All human relationships have more or less explicit

purposes and rules: They involve a power balance between the participants and serve as a framework for the expression and enactment of complex mixtures of narcissistic, aggressive, and libidinal desires and scenarios.

Strangely enough, many contemporary authors who constantly talk in relational terms seem to have little to say about the actual variety and dynamics of human relationships, and they tend to reduce them to some narrow basic models—usually built around the gratifications of presumed primary relational or object-seeking attachment needs. The specific aspects of the analytic relationship have also become blurred, except for statements that it should be genuine, spontaneous, mutual, authentic, and the like. It sounds at times like the description of a perfect friendship or maybe a sublimated love affair, but it is some ideal mother–infant model that is usually invoked.

Here, one must give Renik and also Mitchell (1988) credit for mentioning at least in passing what I consider to be a very important and usually ignored point: namely, that the mother–infant model is hardly compatible with an analytic relationship that stresses equality and the patient's autonomy. Hidden behind concepts of empathy and symbiosis is the fact that the mother–infant relationship is probably the most fundamentally unequal human relationship. One can get around this problem by invoking different coexisting levels of interaction in both analyst and patient, but this does not dispose of this basic paradox.

OGDEN, INTERSUBJECTIVITY, AND THE ANALYTIC THIRD

Another aspect of the new look at the analytic relationship is the popularity of the concept of “intersubjectivity.” This originally philosophical expression has acquired multiple connotations, and you will find it hard to discover a clear-cut, agreed-upon definition. Intersubjectivity stresses that the analytic situation is the interaction of two subjects rather than a subject taking the other for an object. The experience of each subject is shaped by the presence and influence of the other as a set of reflecting and distorting mirrors, in ways which are hard to isolate and pinpoint. For instance, the analyst’s picture of the patient is partly his construction, a reflection of his subjectivity, as well as the result of the effect of his presence on the observed behavior of the patient.

Intersubjectivity highlights the unconscious aspects of influence and communication and the constant interplay of transference and counter-transference. Much of the ongoing data of an analysis are the product of a unique interaction, a shared new creation coauthored by both analyst and patient. Thus, at least at the initial level, it may be hard to tell where things start and who is doing what to whom. Ogden (1994) has called this dimension of analytic experience the “analytic third”—an intermixed, merged
creation which interacts “dialectically” with the two separate subjectivities of analyst and patient. For Ogden, the intersubjective data are only part, and not the whole, of the analytic interaction. Clinically, with Ogden and others, the emphasis has been primarily in one direction: namely, on the unconscious influence of the patient on the analyst and how the analyst can make use of his awareness of this influence to help his understanding of the patient.

Here the Bion version of the concept of projective identification plays a major role. The Ogden/Bion model assumes a greater permeability of boundaries in the mutual regression of the analytic situation; thus, dissociated aspects of the patient’s unconscious will become projected into the analyst’s unconscious and influence him. Projective identification becomes a way of unconsciously communicating and influencing the analyst. The analyst’s unconscious becomes a container for some of the patient’s unconscious projections as communications. In terms of technique, the analyst will be able to capture some aspects of the patient’s unconscious by paying attention to their derivatives in his own mind—in other words, to the derivatives from his own unconscious as they surface to awareness—for instance, in the form of peripheral, unfocused thoughts and reveries.

This is vividly illustrated by Ogden in several extensive clinical examples. In one of the most dramatic ones, he began having various physical symptoms (difficulty breathing, etc.) during the hour and became worried about illness and death. The patient suddenly turned around from the couch to look at him, thinking he may have had a heart attack. Ogden then interpreted his symptoms and her enactment as the expression of an unconscious fear that she would kill him if she let herself be fully involved in the treatment (she had kept a strained emotional aloofness). Ogden claims that this fear/wish of his death was unconsciously projected into him and registered through his psychosomatic symptoms and fantasies of death and illness.

Other variants of Ogden’s approach have been evident in the contemporary literature under the concept of enactment—the enactment being mostly the analyst’s enactment of the patient’s unconsciously expressed desires and projections. That much communication occurs at an unconscious level has always been assumed. And the belief that some of our intrusive unexpected thoughts or sudden strange moods may reflect the influence of the patient and the atmosphere of the session is hardly controversial for analysts. But attributing them to direct projections from the patient’s unconscious seems to me at best a promising hypothesis, to be used with caution.

There may be little direct resemblance between our reaction (a peripheral or somatic expression of anxiety) and what in the patient may have triggered it (e.g., an unconscious hostile impulse or fantasy). Our reaction is bound to be selectively registered and reinterpreted by our own unconscious and conscious concerns. Here I would agree with Renik (1995) that projective
identification assumes that the analyst can be a clean container for the patient’s unconscious in a direct and uncontaminated way (a Kleinian heir to the blank screen).

Besides Klein and Bion, Ogden refers to Winnicott’s mother–infant model and the presumed direct communication and intuitive unconscious attunement existing there. But he also has to assume a separate observing analytic self who can accurately retranslate the manifestations of the intermixed, intersubjective third and trace them back to their original form in the patient. We should add that Ogden (1994) sees no need to challenge the need for neutrality and for an asymmetrical relationship. We are not dealing with “a democratic process of mutual analysis” (p. 17), and the goal remains a better understanding of the analysand’s experience.

It seems far from clear what status is to be given to this kind of intersubjective communication and to projective identification in general. Are we assuming unconscious messages and signals from the other, which are unconsciously and automatically registered, processed, and interpreted in ways yet poorly understood? But unconscious preverbal and mostly pre-symbolic communication is likely to be rather global, diffuse, and affective rather than cognitive. The direct transmission of specific thought and contents seems a rather dubious assumption. So are we dealing with a powerful shared fantasy of extra sensory thought transmission, a literal merging of the boundaries and contents of two minds, a quasimystical union, or something of that sort? Psychoanalysts should be the last to dismiss the power and psychic reality of shared fantasies. The interpretation of unconscious aspects of communications and their reverberating influence is an important and fascinating issue, both clinically and theoretically—but an issue full of risks and complexities.

A VIEW OF THE ANALYTIC RELATIONSHIP

The issues mentioned so far all imply different views of the analytic relationship. Let us go back to a few basics. The analytic interaction is obviously a two-person relationship. But what kind of a relationship? What is specific and special about it? What are its purpose and aims? The answers to such questions are always tied to a more or less explicit particular theory of treatment, of psychopathology, and of mental functioning and human relations in general. Different approaches differ in their readiness to acknowledge and articulate their goals, premises, and theoretical assumptions. There is also no doubt that, in any particular analytic interaction, the specific individuality of the two participants shapes the relationship; however, the importance attributed to this factor is quite variable.

So let me briefly restate what I would consider some of the minimal defining features of an analytic relationship. Its minimal actual reality includes
the physical features of regular scheduled meetings in a private setting and
the duality of roles, with the analyst first and foremost an attentive, alert,
and open-minded listener—and the asymmetrical focus on the patient,
who, whatever else, is paying for a professional service. Behind these rather
strict, narrow, and protective rules, the relation as experienced can become
whatever the patient makes of it (transference in the broad sense), but also
how the analyst experiences it. The psychoanalytic situation in its concrete
reality offers a very limited range of actual gratifications and frustrations.
Within the classical framework of a kind of protected playground, it aims
at maximizing the expression of the patient’s transferences—but also at
minimizing the expressions of the analyst’s countertransferences.

Within these special limits, the analytic situation can provide a range
of expression much wider than the events of daily “real” life. The narrow
but secure base of the analytic relation functions as a stage on which an
unlimited number of scenarios with a multiple cast of characters can be
enacted—while keeping what has been called its fantasy character as play-
ground or transitional reality.

The analytic situation is more than an ordinary two-person interaction,
but one where many selves, many voices, and introjects become present
and can be identified. This involves more than the familiar dual roles of the
analyst as participant and also more detached observer, and the split in the
patient between the experiencing and observing ego. With the patient, the
voices and presences of all the central figures of his life, present and past,
real and imagined, are given the opportunity to come out of hiding and his
unconscious scenarios to find some symbolic but partly shared and exter-
nalized enactment (ghosts tasting blood, Loewald, 1960).

And the analyst, for his part, may, in addition, feel the presence of his
own analyst(s) and various patients, colleagues, supervisors, and family
members looking over his shoulder. As Loewald put it, the analyst is a codi-
rector and somewhat of a coactor on the special analytic stage. The patient
needs to be fully involved in the play, yet remember that it is a still a play.
When Strachey already in 1934 wrote that “the analytic situation is all the
time threatening to degenerate into a ‘real’ situation” (p. 146), he was refer-
ing to a blurring of the patient’s sense of reality. I think that the analyst’s
highly personalized intrusive presence can have the same effect.

Another relevant, well-known, but usually minimized factor is the enor-
mous lengthening of the average analysis. A 10- or 15-year relationship is
likely to acquire a very different and more concrete, self-sustaining reality
in a patient’s life than the 1- or 2-year analysis of yore—the time when
much of the main theory and rationale of treatment was formulated.

All of this touches upon the long-standing debate about the relative pri-
macy as mutative agents of interpretation and insight or the “relationship
with a new object.” The issue has a long history and was already central in
the wild and original experiments of Ferenczi. Freud is supposed to have
said, “We treat our patients with interpretations but they cure themselves with transferences.” Of course, both factors are involved because interpretations can only occur in the context of a relationship and provide the most direct and powerful material, and this relationship is manifested primarily through interpretations, in the broad sense of verbal speech of some kind. But the emphasis is different: In one case, the relationship is used to give power to interpretations; in the other, interpretations are used to enhance the power of the relationship.

The issue of the intrinsic importance of the actual relationship seems also linked with two different images of the analyst. At one extreme, we have what may be called the classical view: the analyst as expert, defined by his training, technique, and his role and function in the special analytic situation. Such a model downplays individual differences in analysts. In principle, there would be only variations on the theme of the well-analyzed and well-trained analyst.

At the other extreme, there is the romantic model of the healer or guru who acts through his intense charismatic presence and offers his individual wisdom. This model, of course, emphasizes the crucial importance of the individual analyst and the unique, specific relationship; it is more narcissistically gratifying. And, in general, it downplays the role of theory and technique in favor of improvisation and creative spontaneity. Most analysts in their attitude and self-image are probably some combination of both these models.

Broadly speaking, relational approaches claim to be more, natural, experience-near, and theory-free. I think this is largely an illusion. Patient and analyst experience the relationship through their own theories and interpretations. Try to banish theory and it will sneak back under the guise of spontaneous intuition and receptive, unbiased openness. For the analyst, his very subjectivity is shaped by his theory, just as his choice of theory is an expression of his subjectivity. His theory will preselect the type of transference he anticipates and finds in the patient, as well as the aspects of it that he is likely to accept, leave uninterpreted, and help enact as part of his countertransference, whether he sees himself as knowledgeable wise father, holding empathic mother, or other prototypical imagined role.

And the patient, for his part, interacts with an analyst that he has constructed himself out of fragments of the analyst’s actual behavior, amplified and fitted within his transference scenarios. It is with this custom-made analyst that the patient has his primary analytic relationship, which is usually continued as a more or less vivid presence and dialogue in between the sessions. I think this relationship beyond the actual 4 or 5 hours may play an important role in the course of the analytic relationship and its eventual internalization. But this would be a whole topic in itself.

Let me add that the analyst may at times feel rather left out in this process, somewhat displaced by yet another “analytic third” as a rival in whom he
finds it often hard to recognize himself. Not being acknowledged as a full partner and given a unique and dominant role may be hard to bear for the analyst’s narcissism and sense of identity; it may lead to such enactments as premature transference interpretations and inappropriate self-disclosures which preconsciously are meant to express, “pay attention to the unique, real me!”

I want at least to mention one last issue. Stressing the unique, specialized, and intersubjective aspects of the analytic interaction increases a conceptual problem always present. How do we generalize from unique and limited data? How representative are they of the patient’s behavior, conflicts, and assets in most of the other situations and relationships of his ongoing life? And how are changes going to generalize and endure beyond termination? On what grounds do we build a general theory of mind and of psychopathology from such limited, specialized, and unique data?

These are fundamental issues, not to be taken for granted or to be disposed of by some vague concepts of structural change, relearning new ways of relating, or whatever. Classical psychoanalysis has tried to manage with various modified versions of Freud’s model of a narrow, standardized situation, providing limited special data (such as the manifest dream) from which an interpretive road to broader and lasting aspects of the unconscious could be built. In all cases, the narrow analytic situation is expanded and interpreted as the partial expression or symbolic reliving of whatever basic and lasting issues a particular theory views as crucial and determining.

It is not difficult to see why it is the relationship aspect of the analytic process which would come across to the patient as most immediate and central. Most patients do not have greater self-knowledge and self-understanding as their most compelling need and primary treatment goal. They want to feel better, and in the process they mainly seek a person to help them, implicitly a relationship that they hope will fulfill some of their desires, disprove some of their worst anxieties and, at the very least, give them the recognition of a reliable, attentive, and understanding listener.

Most analysts have become skeptical about the mutative power of insight and the truth value of any particular theory. Thus, a relationship of some sort may be the most immediate and concrete reality that we offer our patients. The relationship aspect of psychoanalysis is probably its most tangible, positive aspect for the greatest number of patients, but it may also be its least specific contribution and the lowest common denominator, shared with most psychotherapies. Yet I believe that psychoanalysis can be more than an endless attempt to fulfill some presumed primary relational needs and a shoring-up of sustaining illusions. But this belief itself may be only a subjective illusion.