THE CONTINUING PURSUIT FOR COMMON GROUND:

ON BACKGROUND ASSUMPTIONS IN PSYCHOANALYSIS

While the pluralism of psychoanalytic viewpoints in the late 20th and early 21st centuries generated a peaceable kingdom and polite polemics among analysts, it also has failed to unify the field (Strenger,1994; Leuzinger-Bohleber, 2003). Are we left, accordingly, with a Tower of Babel? When analysts of different stripes assemble and listen to a colleague's extended clinical process, do none experience clinical resonances or a sense of commonality?

It depends. If the material is tightly bound to the lexicons of the varying analytic paradigms, the sense of shared ground bogs down. This proves to be the case even if the most familiar rubrics are called up, as when Robert Wallerstein sought an encompassing frame by way of the basics. He hoped to show that we can, after all, rise above theory variegation, and that our "paradigms" are unifiable enough. He attempted to demonstrate how all practitioners apply three conceptual tools in their work: defense-and-anxiety, conflict-and-compromise, and transference-and-countertransference, evinced by detailed process comparison of three similar cases (1992a).[1] Given the chorus of criticisms, however, he came to wonder "whether it is desirable or even possible to continue such a search" (1992b, 2005a, 2005b). After a theorizing century, it seems, the meanings of even classically basic rubrics have become too widely dispersed to establish that claim.

On the other hand, some theorists, including this author, propose that common ground does underlie what we do at *a level more elemental than our lexicons allow*, and that we can describe. All depend on extended presentations of the raw clinical events—

[1] Extensively presented by classical, Kleinian, and Middle-School analysts (Rome IPA Congress, 1989).

sequential process—for these insights or findings. The particular suggestions differ considerably. Some focus on content, some on process, on method, or all: they identify what I call *background assumptions*—recognizable clinical features or markers of analytic work that afford significance, be it in the dyad's interactions, or frames of mind or behavior, or life, of patient and analyst. It makes sense that taken-for-granted practices and ideas, if not trivial, may provide the best candidates for shared ground.

But—if these matters *are* commonly taken-for-granted, why do we bother?

It is because they may, in time, yield the unspoken *lingua franca* of analytic work, and help to overcome pluralistic divisions. Once adequately articulated, these become suitable for further conceptual and empirical examination, for agreement, and for testing—because *these assumptions are observable phenomena.* We shall first consider those of note from the literature. I will propose five more that have a narrative core.

REVIEW OF CONTRIBUTIONS TO COMMON GROUND

H. Smith's continuing call to recognize shared clinical practices

Henry Smith, tuned to the vibrations pulsing beneath the clinical work of analysts who present cases in detail, intuits a commonality there. He does not sketch out its features, but recommends a strategy (Smith, 2001, 2003, 2005, 2008). "Because we do not really know what other analysts do…or what *we* do in…the clinical moment, [were we] to take a clinically near view… at a lower level of abstraction…the arguments that support one theory…over another might not look so clear. I am talking about…all those unspoken and largely unknown criteria by which an analyst intuits the degree to which he/she is, or is not, on the right track" "…if we were to examine the practices of every analyst's school carefully enough, we would find that informing each analyst's approach

are certain fundamental [assumptions, and] they might not vary". "Despite Grotstein's Bionian terminology…when he describes his clinical work, the choices he makes, his interventions, and the manner in which he uses his own subjective experience of the patient [it] would…feel familiar to analysts of many different persuasions". But his approach is hard to fulfil. Were there only a psychoanalytic ethologist to observe and listen neutrally to what actually happens, we might more ably capture and conceptualize these elusive, basic and *shared* judgments. Short of that, we'd best hope, through strategies for discovery, to locate assumptions more basic than paradigmatic rubrics.

Smith's suggestions notably align with what Wallerstein had earlier laid out for such a project (1992c), and that Stepansky, in his overview, advised (2009). Wallerstein was incisive: look to *clinical frames of reference*, and to what is *experience-near*, in "clinical-object" language versus metapsychology-bound terms. Stepansky, in trenchant analyses of analysis per its insufficiencies and pluralistic failure to integrate, proposed as a rational corrective, *a bottom-up search for and study of background assumptions*.

Metaphor as gem in the lode: Bernardi's thematically resonant "anchor points"

After the otherwise insoluble controversy over common ground between R.S. Wallerstein and André Green, the latter had allowed that—at least—a path to overcome the dilemma might be achieved: provide *long enough* series of clinical process for study by analysts of different persuasions, to see if some commonality emerges (2005). Bernardi's current search presents just such an approach. Bringing analysts together in systematic group exercises, Bernardi has them follow an extended single case process (over 10-12 hours), organized by three graduated levels of inquiry[2]; these tasks focus on

[2] Bernardi's instrument, the "Three Level Model of Observation" (p-2018:).

what relates to changes in the patient, his life, his thinking, and his behavior within the analysis. More than 1000 analysts have so far participated.

Bernardi is keen to discover *how analysts respond in similar ways* to particular aspects of the material, *regardless of their later interpretations*, as well as identify common points of contact in the unfolding process. At the beginning, the focus is *phenomenological*: analysts are asked to share what in the clinical material "resonates" with them and "stands out"—*deferring interpretation*—and what fragments suggest unconscious meanings *without yet knowing what is pointed to*. This turns out to be *metaphors or images* in the presented case, that resonate in the participating analysts most often, and that Bernardi designates as "*anchor points*," i.e. for later understandings. This approach leads to *discovering* elements that evoke what analysts intuitively regard as potentially significant clinical markers—without first knowing what these indicate.

This model sidesteps the rubrics of particular paradigms, such that analysts' experiences *tend to erase theoretical differences*. Bernardi reports, in fact, that one analyst remarked that it was the first time he could not clearly identify theoretical backgrounds of other group members "after many hours" [and] "This reaction is common among the discussion groups, because what participants' interventions show is not so much the theory that inspires as the ways in which they use this theory in practice" (p1303). Thus, these clinicians' *practices* are yielding something in common beyond their theories' surfaces. Bernardi concludes that his findings show "that a kinship exists among analysts' clinical thought processes rather among theories as such" (p1305-6).[3]

[3] Bernardi's second and third levels of inquiry increase the complexity of what is addressed; the second level aligns with operationalized categories of behavior, as indicated in the *PDM, DSM V,* or scales of personality functioning, that are organized at relatively low levels of paradigm-bias; third level questions

Their case described a depressed man who improved over 2 years of analysis. Its exemplar anchor point proved to be fragments clustered around a *defective robot* metaphor, as in "a car with a broken clutch"; the analysts' empathic "shared resonance" tapped depression. Interestingly, Bernardi notes that participants' responses "are not essentially different than counter-transference reactions." He nonetheless concludes that this first, phenomenological level of discussion "is where common ground is manifested" (p.1301). Groups also agreed that the robot metaphor reflects frozen mourning processes, affecting the patient's senses of agency and self, and affect- and object-relations.

Bernardi locates a background assumption of serious weight for us. Considerable phenomenological agreement is supported, in part, by questionnaires. This massive, excellent research might have also given us even greater detail if he had used empirical categorization and statistics; on the other hand, to have designed data collection in that way might have interfered with analysts' experiences in processing the clinical material.[4]

Thematic centrality of metaphor: convergence with earlier and current views

Clinicians have long known metaphors and images to bear a pregnancy of links for the case at hand—as well as the configurations of tone, gesture, or emotion.

Freud notes that "words are a plastic material with which one can do all kinds of things" (1905, p.34). Even so, Freud applies the specific term "metaphor" but once in his Dream book (and not in interpreting a dream!), and a half-dozen times in interpretations of jokes (1900, p.80; 1905). Nonetheless, he richly exemplifies many *metaphorically* illuminated discussions of dreams. It was left to Sharpe to explicitly elevate metaphors

compare analysts' implicit or explicit hypotheses with other hypotheses, toward the development of possible interpretative strategies relevant to specific clinical problems.

[4] The second level also showed good agreement. Bernardi allows that greater reliability could have been demonstrated using operationalized techniques, however, a sector of participants objected to doing so.

as clinical targets, exhibiting conduits for the pulses of desire and emotions, however she limited their referring range to libidinal zones. Voth (1970) and later Arlow (1979) fully broadened the clinical universe of metaphors. Voth advocates for analyzing metaphors, viewing them as nodal for "messages from the unconscious," as when a phrase or verbal cluster suddenly "catches one's attention." Arlow emphasizes that "the communication and interpretation of unconscious meaning is made possible largely through the use of metaphor" (p.763), because "language, inherently metaphorical and ambiguous, permits quick transference of meaning from one phonic representation to another," serving both wish fulfilment and defense. Consequently, Arlow declares the technical implications of metaphor as fundamental, such that "associations to them regularly lead to an unconscious fantasy, and that *transference itself, after all, is an intense, lived-out metaphor* of the patient's neurosis" (pp.370, 382).

Lakoff and Johnson famously elaborated the theory that *all* thinking takes place through metaphor, which itself arises from and within bodily experience (1999), and thus affirm metaphor-centric analysts.[5] Modell (2003, 2011) and Borbely (2009, 2011) separately propose metaphoric functions as elemental in mental processes in both health and pathology. Each restates metapsychology in such terms, re-casting how the mind works, and each proposes a common—and metaphorical—ground for psychoanalysis.

In Modell's construction, the unconscious operates as the metaphorical maker-processor of meanings—*not* manager of conflicts—in dreaming and wakefulness: conscious and unconscious *imaginative processes* are assigned primacy. In health,

[5] They view metaphors as borne in the unconscious transfer of meaning from and between sensory domains, e.g. *up* and *down*, from kinesthetic gravity sensations of verticality and their derivative metaphors, and the *in* and *out* of the body as container, all further mapped from body experiences on to abstract concepts; as well, perceptual constancies provide a sense of safety in changing environments.

emotional memories are metaphorically categorized, with past memories continually re-contextualized in and by the present—a transforming power that fails in the rigidity of traumatic states. Borbely entirely revises metapsychology as *metaphorically re-defined* elemental processes, within which metaphors operate fluidly in healthy states, but more rigidly in psychopathology (as "negative metonyms," related to repeated experiences of the past within the present).[6] *Metaphorically re-experienced* interpretations of transference induce neurotic defenses to become "transfigured," over time, into healthy ones. He declares the inherent vagueness of metaphors as desirable, allowing experience to continually integrate with newer meanings in changing contexts, a process he considers "without end" (p.67).[7]

Clinical accounts across the spectrum commonly feature metaphorical words and phrases as reaching *beyond the verbal register,* into what is ordinarily inexpressible, such as wordless images, emotional experience, bodily states, frozen and stuck frames of mind, unmastered memories, and what is pertinent but not conscious. Lacanian analysts have long shared this emphasis on metaphor (Fink, 2004; Bailly, 2009); post-Bionian field theorists vigorously set metaphors into play interventionally, not only drawing on the patient's figured speech or narratives, but the analyst's own immediate reverie-thoughts as well; Civitarese and Ferro stress the selection of "apt" metaphors, attuned to and conveying the patient's "anxiety-inducing emotions at their point of urgency" (2013).

Metaphoric capacity as central and catalytic for change and understanding

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[6] But retaining the *re-defined* labels of "transference," "interpretation," and "defense." In his view, his theory revision solves the conundrum of how to differentiate healthy from unhealthy compromise formations. Caston has also proposed to have solved the latter question, but through operational criteria that clinically distinguishes competent from failing agency (2011).

[7] Similar to E.A. Levenson on this point. See below.

Significantly, Bucci and her co-workers have mastered this focus as an *area of cognition* in their empirical, psychoanalytic research: our capacity to grasp what is subsymbolically expressed. That is, while *symbolic* covers those accessible words and non-verbal images *manageable within* consciousness, *subsymbolic* names what is less consciously controllable, such as emotional and bodily states, and unmastered memory narratives, whether conscious or unconscious. Bucci labels as *referential* those words or phrases *used to express* what is subsymbolic. The measure developed to assess this capacity, designated as *referential activity*, indicates a processing "style" of emotional cognition (abbreviated as RA—a label inordinately abstract for what taps and captures near-ineffable experiences through colorful, often poetic words). As Bucci puts it, *metaphors "are the quintessential indicators of the RA dimension"* (p.188, 1997). RA is applied to many texts, including recorded analyses, and assesses *the words of analytic sessions in full*. It offers a powerful view of how much patient or analyst speech captures what is subsymbolic.[8] In contrast, analysts' clinical reports offer insights tuned to the salience of *key* phrases or interactions, as remembered, for the case at hand. High RA by both patient and analyst, moreover, predicts success. In treatment, as she puts it, all "must be poets [and] use metaphor [in that these may] evoke the emotional experience with some of its subsymbolic components," permitting a listener to reconstitute its elements.[9]

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[8] Remarkably, this measure correlates with the extent of concurrent *hand gestures* (!) while speaking.

[9] RA is judged by the degree to which words tap concrete sensory imagery, carry clear narrative detail, and use imagery likely to evoke subsymbolic experience. As further refined and computerized (CRA), *it sidesteps inter-judge reliability*. CRA comprises the 100 highest RA and 100 lowest RA words, accounting for 50% of normal speech. Bucci here describes the *referential cycle* as recursive stages within treatment: arousal/activation of the patient's subsymbolic state, at first experienced ineffably; then a symbolic phase wherein *prototypic* subsymbolic experience (e.g. emotional memory) connects to symbolic forms, often in narratives (memory, fantasy, free associations, trivia) metaphorically employed; and a final, reflective phase, better understood in "shared referential space" within the therapy dyad, with potential for change.

The bond of safe company: background feeling (Sandler); epistemic trust (Fonagy); vitality (Alvarez, BCPSG); unison (Civitarese, Ferro—after Bion)

Most commonly taken-for-granted is that treatment provides a safe arena, assured by the frame, within which the couple may freely co-explore matters of concern at a regular time and place, under the constraint not to act out. It is mostly communicated subsymbolically, through an analyst's tone and pace of voice, signals of posture and face, by smiles, eye contact, and through responsiveness and pleasantness that does not seem hollow: these command this arena. Although words of understanding and the flavor of interpretations insure that "matters are basically OK between us," what is verbal rides atop the greater body of unworded and bodily assurances.[10] While an analyst may intentionally signal these, what is presented spontaneously *originates passively*. Urgency and suffering draw responsive, wordless immediacy from a listener, a reaction surely rooted in the swiftness of caretakers turning to infants' distress calls.[11] It engenders bonding and desire in the dyad, and attendant emotions.

These phenomena frame *the bond of safe company*, comprising a family of experiences within clinical and developmental theatres of dyadic engagement, a background assumption shared by a broad range of paradigm-holders. It functions implicitly in Winnicottian holding and Bionian containment. However, some explicitly recognize safety-related features as an element of therapeutic process. As early as 1959, Sandler advanced the concept of a *background feeling of safety*, tied to its associated signal (parallel to the ego's anxiety signals), as a *continuously monitored* conscious and pre-conscious experience, and as a much taken-for-granted aspect of successful clinical

[10] Some analytic couples shake hands at the end of every meeting, no matter how stormy or negative.
[11] Shown to be a fixed response across all mammalian species (Angier, 2017).

work (1960). In this ego-psychological one-person framework, safety, like anxiety, plays an essential dynamic role—but wherein the mother, like therapist, has featured as prime protector; this concept, thus, is implicitly and ultimately "two-person" (p.80). Pointedly, by proposing the *safety principle* as parallel to the *pleasure principle*, Sandler elevates its status, and underscores its primal power as much as pleasure (Sandler & Joffe, 1969).

But Sandler failed to credit Bowlby's relevant contributions. The latter proposes how the mother's protective and emotional availability proves central (1958; 1973), features foundational for the landmark attachment studies by Ainsworth (1978) and Main (2000) and Hesse & Main (2000). Attachment theory distinguishes more—and less—secure forms in caretaker-infant relationship styles, with consequent and lasting imprints on interpersonal capacities, and predicts remarkable associations with development of borderline personality disorder (BPD). Attachment phenomena, indeed, underscore the complexity and importance of safe dyadic bonds.

In formulating a basis for the theory and treatment of BPD, Fonagy and coworkers show how attachment, viewed as a motivational system, and mentalization, interweave (Fonagy et al, 2003). Fonagy construes borderline patients' failure to mentalize as a defensive adaptation rather than developmental deficiency. More recently and significantly, he recently views that his treatment approach, involving transmission and modelling of mentalized understandings to and for the BPD patient, *only* transpires on a broader interpersonal platform: *epistemic trust* (2017; Allison & Fonagy, 2016). Fonagy draws this idea from the work of the developmentalist-philosophers Csibra & Gergely (2006; Csibra, 2009). Epistemic trust is, basically, a pedagogical concept. It describes the universal framework of safety and engagement that induces, indeed,

encourages an infant, or student, or patient, *to learn* in given contexts, that is: the child, with respect to learning to speak its language, how to take turns in talking, or ride a bike; or a student, to do math, accept a technique, or believe a historical story; or a patient, to learn, take in, or thus *believe* an analyst's intervention.[12] The key moves that set up trusting environments for parents, teachers, or therapists, are *ostensive* cues, such as "motherese" for infants, and other notable para- or non-verbal forms of high-lighting such as smiling, tone, rhythm, and so on, that "prove" an authority's invested focus. Commonly, these certify that *the learner's agency is not only recognized, but prized*, and mentalization is another ostensive cue. Likewise, when epistemic trust is damaged, hypervigilance, rigidity, and skepticism may well develop instead of trust, as well as resistance to learning.

When dyadic trust has been successfully set up, salient experiences and emotions result. Pertinent to the development or suffering of human creatures, interpersonal safety most certainly engenders bonding and desire, but wider spectra of intensity, kind, and contour are observed to transpire in its attendant emotions. Many of these have been gathered under the umbrella of the *enlivening company* of mothers/therapists as conceived by Ann Alvarez (1992), and the BCPSG as *vitalization affects* within the analytic couple's "now moments" (2010).[13] Not unlike glissandos and crescendos, affects within the dyad demonstrate a musicality of pitch, amplitude, and shape over brief time spans, in these studies. Alvarez and the BCPSG recognize and share descriptions of this intersubjectively experienced vibrance, e.g. surging, reaching, fading, climaxing, etc.

[12] Csibra and Gergely broadly propose that the phenomena of epistemic trust underly the transgenerational transmission of cultural knowledge, based on the trust of parents and authority figures of the community through history, originating in the period of hominid tool use some 300,000 years ago (2006).
[13] Alison & Fonagy readily incorporate these affective elements in their conception of epistemic trust.

Where Alvarez emphasizes how the initiating or responsive engagement of therapist/mothers serves to alert a patient's/infant's *flatter* moods, the BCPSG note how these shared experiences can swell into "now moments," that they characterize as "fitting together," as an increased coherence of the "dyadic system." Essentially, this is a loving mutuality, felt as genuine, and evoking wishes that it will recur.

The kinship here with the Bionian concept of *at-one-ment*, more simply re-cast as *unison* in the recent work of Civitarese (2017) and Ferro (1999), is evident and striking. Ferro views the analytic pair as a group of two, such that, accordingly, it is not clear which projective identifications belong to whom, and linked to the continuing ambiguity of unsaturated interpretations. Although bi-personal dynamics feature the *couple as an agent*, Ferro nonetheless marks patient and analyst as *separate* agents, in that his declared approach is to be "*in* unison" *with* the patient, a metaphor understood as "being on the same wave-length" (pp. 12-15). Civitarese points to unison (or at-one-ment) as well, not necessarily as representation, but rather as a "truth" like dancers-who-move-in-step, and "on the same wave-length," as a non-verbal bi-personal fine-tuning, or "emotional consensuality." In his view, that a mind develops in the presence of another through unison, as a kind of truth, likely forms one axis of analytic common ground (p.494-5).

Levenson's "therapeutic algorithm" as a background assumption of long-term work

Out of his longstanding clinical experience, E. Levenson paints common ground with a broad interpersonalist brush (1983,1988). "Analysts of all persuasions treat with considerable success . . . and yet are hard put to know exactly how to talk about what they do when they do what they know how to do"; "[and] …there is a commonly held

praxis of therapy" (1983, pp6-8).[14] He asserts that while all easily conceptualize case material, theoretical formulations differ "so blatantly" that our "commonality must lie in some other area," whereas when we listen leaving paradigmatic theory aside, "a certain collegiality does emerge." His assumption is process-centered. He asserts that it is empirically derived, i.e. not drawn from paradigm-metaphors, and configures it "algorithmically," as follows. Under the constraints of the *frame, or "rules" that analyst and patient observe,*[15] how they talk drives toward an elaborating enrichment of the patient's inner and outer life, and elucidating the analyst-patient relationship. He notes how in any treatment, as symptoms—acting out—memories—transference—countertransference spin on and recur, the overall process *continuingly produces new avenues of meaning* that the pair applies to these subject matters. And it is just this process of the deepening, ever-branching clusters of meaning flowing in all well-working treatments that is the assumption he sees and claims as patterns *of* therapeutic working-through. The patient becomes deeper, "equipped," and freer to choose his way. He characterizes this as the recursive, "temporarily chaotic," creative "deconstruction" of the patient's original narrative order. He attributes this algorithm to Freud, who had "unwittingly" applied it in his therapy, but conceived it in an unconscious fantasy framework. Levenson instead insists that this system lies *linguistically* embedded in therapy discourse, and thus more basically, and that it transforms out of awareness.

As a clinician who has analyzed and supervised more than four decades, I can opportunely compare patients' *initial* facility to think about and experience what goes on

[14] As David Tuckett has asserted, "Many analysts cannot easily actually articulate their theory of how they work—they just do it" (2008, p.248).
[15] To not enact in the relationship, except to co-explore matters as freely as possible within a regular context of time and place.

inside them and in the relationship, with their later such skill after several years; and so I readily concur with Levenson's observation that continuing, ever-branching clusters of meaningful understandings develop after extended treatment. Further, I easily judge that such not only represents an *outcome* of good treatment, but enables further growth, following the truism that in time the patient becomes his own analyst (Caston, 2007).

But have we established that it's true across the whole spectrum of practitioners? That needs greater reach. We need to demonstrate reliable agreement about such judgments, that many already take for granted. If it operates within all kinds of analysis, we need be keenly interested to know what, in addition to the safety and constraints of the frame, could the minimum requirements be that bring it about?

A NARRATIVE-EMPIRICAL PATH TO BACKGROUND ASSUMPTIONS

Building on Wallerstein's and Stepansky's perceptive counsels (and resonant with Smith's), the present project considered several background assumptions judged to be regularly present in analytic practice, that add a different strand of candidates for common ground. Each involves judgments about the meaning of narrative fragments of what is told or happens, with commitment to later empirical reliability, mostly within brief moments of process. Dealing with meaning in our work does not absolve us from demonstrating criterial distinctions and agreement. But understanding always precedes establishing confirmability, and completes it. Relevantly, Caston studied the analytic assumptions regarding personal agency (2011), that involve a patient's capacity to become freer—or fail— within her particular domains of concern: it serves as model here. Five, including agency, are presented: 1) C*ompetent versus failing agency* markers indicate therapeutic change in a person's capacities for self-direction; 2) *The courage to*

bear anguish, related to agency, marks progressive change in the moment that relates to strength or resilience; 3) *Surprise* calls for a revised perspective of understanding the other, or oneself; 4) *Merited responsiveness* guides timing for when to respond; 5) *Narrative incoherence* indicates that a person is at cross purposes with herself.

These assumptions—a list of clinical markers that is admittedly open and incomplete—tap the *narrativity* inherent in process. Particular theoretical ideas necessarily ground such a perspective, but no narrative theory can directly provide a sufficient and complete theorizing framework for clinical events. Narratologists and philosophers nevertheless offer concepts to organize what is said or happens, useful for thinking about our work. As follows, ideas extracted from Ricoeur, Genette, Altman, and MacIntyre relate to the task at hand: to judge simple *in-the-moment* aspects of process, grasped narratively and in context about which we can make comparisons.

This approach joins narrative understandings and criterial description, and moves toward agreement—with the ultimate goal of testable validation. Such, however, resurrects the hermeneutic vs. scientific knowledge conflict. In this regard, Paul Ricoeur offers to ground such enterprises, by overcoming this divide through a dialectical fusion of both perspectives (2007). In Ricoeur, causal and intentional consequences of human action intertwine. He describes the "interpretative arc" as beginning in naïve understanding, refined further by (scientific) explanation, and finalized as informed understanding. He incorporates, moreover, Hirsch's rules for validating interpretative guesses: not just any interpretation "goes," *but should be more probable than another*. This, he notes, points to criteria of *in*validation, comparable to Popperian falsifiability. Empirical treatment, accordingly, needs be sensibly integrated into our project.

Here, clinical fragments are *micro-narrative* in character, and rest on Genette's clarifications about "minimal narratives," out of which episodes, stories, or novels develop into grander amplifications, e.g. "Ulysses comes home to Ithaca," "Marcel becomes a writer" (1980). But they can be quite small, essentially verb- and agent-centered, and thus one's spotlight need not address large swathes of text.[16] Even such nugget-sized statements, he indicates, evoke senses of anticipation and conclusion. Altman complements this point in another way, observing that people who regularly skim texts or surf TV channels recognize the sampled fragments *as* narrative: "middles" *without* beginnings or endings (2008). He delineates *framing* as the further process whereby an author, or we onlookers, design beginnings and endings to texts. As he puts it, even daily life is not narratively constituted until a "naturalist novelist cuts it into slices" that he or she then *frames,* to reveal its implicit, bite-size narratives: a process not unlike, remarkably, what clinicians do.

Narratives of real daily life, however, call for additional conceptual tools: *intelligibility, context, and accountability*. "No matter how changed I may become," as MacIntyre puts it, "I am forever what I have been, and called to answer for it" (1984). What we do raises the matter of the *unity of ourselves as persons* through succeeding changes, and each action finds intelligibility and accountability within its far and recent historical contexts. You can't *identify* a person's action unless you know the history of his goals and beliefs in context: in MacIntyre, if a man gardens he distinguishably may do it to please his wife, or hope for vegetables in spring, or fashion a social image. We only need hear a piece of a conversation to grasp it *as* intelligible, placing it as a pattern

[16] The tiniest model of a micro-narrative involves no more than an action and agent, with or without an object, e.g. "Sally drives a Prius".

within a genre (a "drunken brawl," a "comic misunderstanding"). Unable to identify this specificity, says MacIntyre, we are baffled: is it culturally alien? neurotic? psychotic? And from our viewpoint, it is the analyst's task to find the contextual home for the understandable narrative that resides in a problem piece.

To sum, important narrative assumptions about the clinical theatre and its events require that its spoken/enacted fragments be plausible in context, such that its intelligibility is worthy of provisional belief; and that the person as agent persists through the span over which these fragments unfold. Thus, much discovery of meaning in our work is narratively guided, and the meaning of "meaning" may be conceived, I suggest, as follows: *meaning takes place in a narrative structure in which someone or something has a stake in the actions, experiences, or the consequences that come about at each point in time, in the light of its historical context.*[17]

Failure and Competence in Personal Agency

A patient who overcomes inner constraints, becoming *able* to make choices and enter actions, demonstrates a significant dimension of healthy change, and we can easily intuit the opposite: if a person is "stuck" and *can't* start (or *can't* stop or *can't* continue) an action when it ought to be within his potential powers—or is "driven" such that he *must* continue acting (or *must* start or *must* stop himself), then he remains in a realm of neurotic functioning. Clinical markers for *competent and failing agency* thus gauge aspects of therapeutic change in a person's power to self-direct, i.e. his capacity to

[17] We cannot say this about thermostats, chess-playing computers, or robot-cars at traffic signals, even though all have historical narratives. Grunbaum, noting transformation histories of rubber bands and magnetized metals, challenged the hermeneuticists Habermas and Gadamer, who declared that *only* psychological/interpretive disciplines are historical, in contrast to the essentially "*a*historical" empirical sciences. (1994). But even so, thermostats and rubber bands have no stake in what they do or did do, whereas creatures do, despite Grunbaum's indictment of "meaning" as a "weasel word" (p.55).

choose, deliberate, and initiate options. These, presented as background assumptions in Caston (2011) are laid out as observables: three experience-near criteria apply to *domains of action*, within which a person can act or think *reversibly*, *self-observingly*, and *appropriately*. "Domain" is key here, deriving from how we make before-and-after comparisons, by tracking *particular* arenas of troubled action; the potential performance range is polar, and full competence to act reversibly within it, is optimally *dual*—both to be able to do something (e.g. be boastful) and also able to elect its opposite (e.g. be modest). There are thousands of everyday domains, e.g. to be able to be close *or* to distance oneself, to be able to speak up *or* shut up, to be able to make love *or* abstain, and so on. Freud's therapeutic rule of thumb, to optimally love and work, designate domains that are just not fine-grained enough. For instance, the too-broad domain of *work* sensibly divides into clinically distinguishable ones, such as working alone, rather than in collaboration, or by improvisation, or as a leader or soldier, etc., and in which one may be conflicted or free in one kind of work, but not another. These external observables do not depend on the lesser rigor of a person's self-report of a *sense* of agency. In addition, the competent freedom to enter an action or state, or flexibly elect *not* to do so, need *not* be socially adaptive, i.e. such that one can be free enough to "break the rules."

The conceptual registers of these criteria differ. *Reversibility* describes the range of a person's power within *each* domain, *in which moving toward one pole does not necessarily serve as a defense against the other* (as see A. Kris, 1982), e.g. a person may freely clean *or* soil himself, in contrast to rigidly or defensively. When these are not free actions, they are *descriptively* conflicted, marked by inhibition, drivenness, or contradictoriness. How much action may fall under *self-observation* serves choice-

making and its ownership. But self-observing *is* an action, and thus vulnerable to conflictedness. *Appropriateness* is a criterion of contextual adequacy, i.e. that intended actions coherently fit the circumstances and consequences. Empirical studies of adult and child settings affirm the reliability of these markers (Blacker, 1975; Caston, 1993, 2011; Caston & Martin, 1993; Horowitz et al, 1978; P. Kernberg et al, 2001).[18]

The Courage to Bear Anguish

Judging *the courage to bear anguish*, as a clinical marker and assumption, assesses progressive and resilient change in the moment. Courage names the strength to face danger, pain, or anguish, believing that one might survive these when not for sure—and in a therapeutic moment, to enter them. Patients daring to edge forward is a familiar feature of clinical work, in which the *valued* advantage of courageous moves outweighs their prospective downsides. Decisiveness invokes and illuminates these scenes, because competent agents not only choose, but *initiate* the action of a prospective choice.

Courage may be experience-near, but is exquisitely complex. In early papers it finds no place. Zetzel, for instance, does not speak of courageousness, but instead considers the bearing of anxiety/depression as traits *in place*, consequent to early survived frustration, an earned capacity she views as resilience or immunity (1949; 1965). In contrast, Greenson's descriptions hew close to the direct language of courage,

[18] Wallerstein's SPC studies (DeWitt et al, 2007) further augment these criteria, demonstrating the reliability of agentic features within the *interpersonal* world in which troubled self-direction takes place. These relate to whether one corrects oneself or needs help: when a person's functioning in a given domain is optimal, he *needs no correction*, as he acts freely; for example, be free to be skeptical, or to worry, or to self-assert, or to be dependent—as well as elect *not* to be such. At a mild degree of difficulty, a person needs correction but is *able to correct himself*, pointing up his self-awareness and reversibility; but a person who can *only* correct herself with outside help (therapy or counsel) suffers moderate difficulty; severe rigidity marks the most troubled level in persons unable to reverse or self-correct, who are often un-self-reflective and difficult to help.

dramatizing what patients fail to, or *do* do, to face conflictedness in moving the treatment along (1967). His clinical theory construes *risk-taking* as a power of the early ego (p.34).

Other analysts address bravery in the outer world, or consider its masochistic or counter-phobic weight (Coles, 1965; Kohut, 1970; Jacobs, 2008; Levine, 2006). Kohut unabashedly valorizes courage, claiming it is, *for most of us, beyond our scope*. Levine's thoughtful review affirms courage as achievable and vital to analysis, yet she cannot disentangle tolerating, vs. seeking pain, and concludes that analysis of any courageous or masochistic act always reveals mixed features of both. On the other hand, she offers a clue for a clinical distinction: "in masochism, the painful state itself represents the aim, while in courage, it represents the means to an end": this idea allows an *observable* grasp of the pragmatic/rational aspects of courage. However, I would put it this way: *You do not have to love misery to bear it*. That is, if neurotic currents undermine a patient's potentially courageous move, then attending to accompanying drivenness, inhibition, or contradictoriness will sufficiently clarify its rigid and pathological defensiveness.

Two empirical studies relate to reliably judging features of courage in clinical micro-narratives: a "*boldness*" measure that represents the patient's readiness to confront charged or conflicted issues following analytic interventions (Caston et al, 1986); and Luborsky's recorded studies of *momentary forgetting* during treatment (Luborsky et al, 1979; Luborsky & Mintz, 1996). Patients usually recover what they just forgot, and the lost idea often reveals *coming into something new that had been temporarily warded-off*—that had arrived from the very edge of what was to be braved, and almost lost.

Surprise and Laughter

Surprise. As unexpected turns emerge in session, surprise occasions new narrative perspectives. Fascination, pleasure, or unease may supervene—emotions and understandings that underwrite our belief in its significance, and call for a revised grasp of the other or oneself. It is a taken-for-granted and ubiquitous aspect of clinical work.

> A patient was thinking about how he had entered the Air Force rather than the Army for required military service years before. He mused that while it was "probably relevant" that his eldest, deceased brother had also done that, he had never felt much about his own choice, and could only offer that he "just really liked" the uniforms' smart look. He was then quiet for a while. Then, out of the blue, he began weeping and sobbing. He was struck by this intensity and its mystery. He had been a young boy when the brother died in a plane accident: although he clearly remembered his family in mourning, he himself had not wept. Surprise now marked entry into grief. Thereafter, ease and suddenness of tears became a familiar feature of his analysis, touching many matters.

> In a different case, a man drily recounted early tales of his dysfunctional family. These included: his father's business failures and desertion, his mother's crass ineptitude, an older sister's sarcasms, and the pathos of their lives. It all evoked sadness in me. I felt compelled to let him know this, as I had sometimes done in similar cases. But on hearing that, he looked at me like I was the most incredible idiot ever for saying or thinking so. I felt an intense astonishment, suppressing it as best I could. How much more unrelated this person was, than I had expected! His emotions were light years away from his access—or from sharing them.

Reik celebrated the place of surprise in analysis as its most "specific mark" in his 1936 work, *Surprise and the Analyst*. He declared that if there is any royal road at all to the unconscious, it is surprise, rather than dreams. In his account, surprise may overtake patient or analyst, over each other's words or actions, or interpretations. Noting that retrospective scrutiny of associations, dreams, or history might lessen this surprise, Reik

asserts that this experience *confirms* the appearance of what has been repressed.[19] But consider that the net of elusiveness that gives rise to surprise might not capture *only* what has been warded-off, but relicts of bias or limited cognition as well.

> A romantically inhibited patient often recounted fierce memories of chagrin at his father's return home after long absence (when he was five), and how it had disrupted his and Mom's idyllic life—climaxing in a scene in which he hurls a shovel at his father's head, only to see her rush in to nurse his wounds. It took two years before we realized one day, with surprise, that it would have been impossible at that age to wield, much less hurl, a shovel. This had likely been no historical memory, but no more than a cherished daydream or dream.

Analysts across the paradigms assert the clinical value of surprise. Bergmann (2011) actually took Reik's seminars, and recounts the enduring influence on him of his idea of "the surprised analyst." Waelder's lectures carried this emphasis forward: analysts *need* to be surprised in clinical work to ready themselves for changes in perspective, and goes further to claim that "surprise is the most reliable proof of an interpretation" (in Guttman, 1987). Likewise, Brenner's extended discussion (in Marmor, 1955) indicates that the *patient's* surprise or laughter are key clinical markers among others, supporting interpretations. Arlow too, stresses that analysts should be "surprised all the time," seeing it as confirming an interpretive tack (in Smith, 1997).

Relational thinkers place high value on clinical surprise for its spontaneity. Stern for instance, valorizes what comes forth "unbiddenly," as it sets surprise up, opposing stale formulas, and leads to creative, beneficial turns (1990). Courting such, he urges, will leave us open to more novel perception. Lachmann and Beebe (1993, 1996) note that

[19] In this, we note he adds *one more* assumption beyond that of the stellar non-triviality of surprise.

mutative interpretations marked by surprise, novelty, and affective urgency serve the repair of dyadic disruption (per cases by Wolf and by Stolorow). Bohm's analysis of the British Independent Stewart's "five agents of change," finds all grounded in elements of surprise and confrontation (2000). Taerk, combining self-psychology and BCPSG viewpoints, also stresses surprise and spontaneity as affording access to increased implicit relational knowledge (2002). Remarkably, even chaos-theory constructions of analytic work mark surprise as key, indicating that it is "isomorphic" with bifurcating shifts in the unfolding process, parallel to the "butterfly effect" (Piel & Schreiber, 1994).

Laughter. Reik linked laughter at jokes to surprise in analysis, as both share a preceding micro-moment of "shock," although, because alarm is not ultimately merited, inhibition doesn't develop. He was prescient to relate the two. Others agree that patients' laughter forms a telling response to interpretations (Brenner in Marmor, 1955; Lachmann & Beebe, 1996; Taerk, 2000). The most satisfying account of laughter has been given by the philosopher Morreall: *laughter erupts when pleasure joins surprise, having been triggered by sudden shifts in cognitive or emotional meaning* (1983). We may conclude: in treatment, *laughter is a subset of clinical surprise*.

Fenichel, too, offers that an analyst's experience of a "click" attending his own interpretive insight or the patient's utterance, marks that knowledge as clinically valid (*i.e.* as a bit of undefended psychic reality). Thus, the "click" probably signals the sense of a pattern match (1941, p.8). Fenichel also connects the sense of surprise with lessened warding-off, especially when *experience* fleshes out what is articulated. Skura further elaborates on Fenichel's "click" and its "peculiar rightness" felt as surprise, often marked

by a giggle-like feeling, an emotion she suggests does not result from discovered content, but is rather a "[narcissistic] response to the act of recognition itself" (1981, p.215)."

Consider, however, that beyond clinical process, surprise and novelty pervade the *umwelt* of rational, primitive, and nonhuman creatures alike (Alter, 2000; and Bruner, 1974, re infants' surprise in pre-verbal peek-a-boo games). Novelty resides within *expectantly* dealing with what comes, whether for voles, apes, or analysands, in communication with fellows or the world at large. More generally, we understand that eruptive affects, not just surprise, infuse a person's experience with *memorability*: therein lies its continuing salience, bestowed value and persuasive power.

Merited Responsiveness: Points of Urgency, Shifts in Voice, and Turn-taking

Points of urgency and shifts in voice commonly command consideration to intervene in *or* mark salient moments. They function as notable background assumptions that guide timing, but originate as subsets within the wider interactional field of *turn-taking*, socially and developmentally acquired, that drives when to respond and how.

Points of Urgency. Ever since Strachey famously recommended (after M. Klein, 1934), that we intervene *at* "points of urgency," the literature became replete with descriptions of having done just that. But what is clinically marked here? Klein directly invoked "urgency" to indicate the *urge of the drives*, but common English connotes the *interpersonal appeal* of a demand or need. *Yet there are almost no systematic studies of this practice*. Relevantly, Boesky privileges certain associations because he feels "they express the most pressing affective pressure of the moment *without* knowing what counts and what doesn't" (Boesky, 2005), and went on to focus on Casement's extreme example of a patient who asked that he hold her hand— though he did not (2013). Boesky found

25 analysts who took yes or no positions re hand-holding at this urgent moment. But it would be more interesting to demonstrate, for common ground, that analysts generally intervene at similar points, *whether* at merely ordinary or extraordinary moments.

Fine & Fine examined whether 24 analysts from different paradigms, asked what interventions they might make *and when*, could be differentiated as to style, focus, language, etc. using the *same* process transcripts, minus actual interventions (1990). Separately, "blind" analyst-judges categorized and rated these responses, which show that Kleinian, Kohutian, classical, and Kernbergian analysts can be statistically distinguished by many features. But more pertinently, most interventions were *made at similar places*, demonstrating that across paradigms, we are drawn to speak at the *same entry points*, while interpreting divergently. *This finding indicates commonly grounded triggers.*

Shifts in Voice or Style. Even subtler features of process commonly alert clinicians to speak. In this respect, Bernfeld reconsidered analyst-patient exchanges *as a conversational flow* (1940), wanting to mark *observable* disruptions in it. Bernfeld saw that these sequences are not unlike the common drama of a friend who begins to talk normally, but, because a secret matter might emerge, alters her voice or its smoothness; and if afterward it becomes safer to tell or confess, conversation eases. He thus clarified that analytic process operates as a conversation with conscious and unconscious disruptions. Usually, analysands go on without impediment. At some point, however, they may *hesitate, switch subjects, or slow down or speed up, or their tone morphs oddly; or more, they may grow silent or less coherent*. A strong parallel obtains between such events in adult treatment and the "play disruptions" of children's therapy, as when a child

abruptly shifts or stops the course of smoothly flowing imaginative play (Erikson 1940;1950). Analysts notably intervene at such a place or mark its significance.

***Turn-takings*.** Analytic considerations to intervene at points of urgency or shifts in voice seem on their face to differ from common talk, and, after all, arise in theory. But everyday *non*clinical speakers hold assumptions in taking turns that are acquired outside awareness: *when* to talk is a deeply embedded practice, a largely procedurally developed social matter, with goals not born in theoretical argument. In treatment contexts, they operate right alongside, or inside, analytic listening and its interventions, functioning as *cognate derivatives of close or intimate moments in life*.

Ethnomethodologists' studies demonstrate that the daily phenomenon of speakers' turn-taking is profoundly organized, consistent, and appears invested with a moral force to keep a conversation going and end it with resolution, or, if failing, to repair it. Garfinkel (1963, 1967), originator of this discipline, assimilated views of the social phenomenologist Schutz (1962; Heritage, 1984), who had proposed that speakers unconsciously hold two assumptions: 1) people who talk with each other *expect* they share similar views and interests; 2) they tend to idealize these positions, preserving a sense of commonality.[20] *In sum, when we speak to each other, we tend to share expectations*. *When these are thwarted, Garfinkel repeatedly found that dramatic results emerged*. Not responding to ordinary greetings, or pushing for excessive details on mundane matters, evoke righteousness, outrage, indeed, "immediate breakdowns" in interactions. Thus, speakers hold each other morally *accountable* for what, when, and

[20] Schutz develops these ideas as observer, but they overlap with Grice's guidelines for rational discourse in speakers' direct and indirect meanings, based on listeners' presumptions that speakers will engage cooperatively, by speaking 1) truthfully, 2) informatively, 3) relevantly, and 4) appropriately (1967).

how they say it. Typically, each listens intuitively to the variations of the other's *spoken immediacy, pitch, rate, and hesitations*, to judge live exchange for how to proceed, and often repair talk that's gone wrong. Anticipating a negation, they intervene to avert a disruption. If repairs fail, the other is suspected of "being *up* to something."

Speakers generally move to preserve their bond, tuned to what's going on—a close cousin to the process of treatment. But deeper roots than this influence therapy.

Turn-taking's Developmental Origins: Rhythm and Play. Shifts in voice and points of urgency, clinical markers that form, in part, out of the unconsciously acquired conversational practice of taking turns, also likely originate in repeated dramas between mother and child *that are not in words*. Wordless but meaningful backs-and-forths precede the narratives that later come to fill these place-holders.

Bruner's study of mother-infant pairs (4th through 24th months), demonstrates that mother-and-child practices, *before* there are words, persist as they later pass into mature, spoken speech (1974). Pre-verbal turn-taking in mother-child play happens in game-like situations: disappearance and reappearance of objects, faces, and persons. *The child's experiences here build on expectations of the other's regular moves*—with pleasing peek-a-boo surprises arising from variations.[21] Mothers use the infant's wordless vocalizations to begin, and then extend into, words that *supplant* the simpler place-holding utterances. *Ultimately, the source that calls the rhythms of responsiveness in mature conversation, and therapy, is utterly primeval*, and underlies the patterns of clinical intervention.

[21] In the earlier months, the mother "highlights" objects for the infant. As word use begins around the first year, highlighting drops out. Game-like formats offer opportunities for interchangeable roles, i.e. turn-taking. By 18 months, via a kind of mother's "handover principle," *the child itself initiates and directs* the disappearance-reappearance games.

But Jaffe and coworkers (1970, 2001) find an even more primitive, pre-symbolic aspect of turn-taking that operates *regardless of content*—its "music," as it were, played out in dialogic tempos and rhythmic patterns, whether worded (as among older children or adults) or only vocalized (infants-and-mothers). This procedurally organized feature relies on the *memory of pauses* between turns, for the several preceding, and operates outside of awareness. Here, *both infant and adult speakers tend to match the durations of* "*switching pauses*," the silence after one speaker ends and the other begins! Speakers and vocalizers, and their listening partners, contextualize each other, modifying each other's rhythmic units over time. Accordingly, the primeval origin of responsiveness likely underwrites its background and guiding role in ordinary and clinical conversations.

Narrative Coherence and Incoherence

Narrative incoherence indicates that the patient or analyst is at internal cross purposes. We familiarly take for granted that *any* instance of an irrational or puzzling thought or action must have been intended or wished for by the individual, an assumption we owe to Freud. His *Psychopathology of Everyday Life* compendiously offers model inferences that fill the gaps about what is puzzling, creating plausible narratives regarded as not only unconscious, but intended (1901). *But is such universal?* Freud notably counters with a distinguishing criterion: not just *any* puzzling content deserves credit as unconsciously motivated—*only striking instances* of forgetting or other faulty actions are candidates. Thus, puzzling narratives that *do not* sink to this level of suspicion do not merit to be considered "motivated," even if not conscious.[22] [23]

[22] E.g. fatigue, burden, senility, "true" accidents, glitches in procedural memory, and so on.

[23] Beyond slips, the range of incoherence spans psychotic sequences as an extreme, but includes sense-making, however vague, communications. The Adult Attachment Interview captures this subtle form of incoherence, by assessing how people relate personal history in a semi-structured format, following

> Long before I was formally schooled in the study of things mental, an acquaintance, embittered by unexpected motherhood and the delay in her projects, was complaining—again—about baby troubles. Now she was newly saddled by her child's outbreak, she said, of "*infanticide* eczema," and went right on to other details of parenting travails, without noticing what she had just said. A chilling slip. She obviously had meant to use the pediatric label "infantile eczema." I was not about to call it to her attention, then or ever.
>
> And long after I had become a seasoned analyst, I had been talking with my older brother after our father's memorial, when *suddenly I could not retrieve his name!* And this went on and on, interminably, and in fact I never recaptured it on my own. Someone else relieved me of this puzzling embarrassment by calling his name out—"*Ike*." It was an exact instance of Freud's requirement for parapraxis—that forgetting must be striking and unlikely.

These examples stand out like off-stitches on a Persian rug, punctate interruptions in the otherwise even weave of mundane narratives, easily engendering the immediate belief that "there's *another* story going on here." That understanding usually arrives whole, coupled with its simple first-order interpretation. Our drive to explain does not allow us to wave these moments off as glitches, incoherent as they are. And here, even without further clues or associations, alternate tales are likely to be darker ones. Admittedly, it's easier for me to posit that young mother's unconscious stake in the disappearance of her child from her life, than of my brother from mine.

> In the genial, sad, and serious atmosphere after the memorial I had not expected myself to be ambivalent, and remained troubled and puzzled by my lapse. Weeks after, half-waking and pre-occupied with it again, I was thinking

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Grice's maxims of conversational cooperation (quality, quantity, relevance, manner), and with good reliability (Crowell et al, 2003). Those identified as less securely attached perform significantly worse. The reliability of the judgment of slips are reviewed mainly in experimental formats (Stemberger, 1992).

> "We call Isaac 'Ike,' but we call him 'Ice' too, in affectionate teasing . . . and thinking of ice, I thought of the ice and dust—that comets are made of—comets, bodies that come around but seldom visit, more like myself and not him—he'd been the better son in our parents' care: a lame start for an understanding, but enough to grasp my guilt and envy, and enough to disappear him from my words.

Narrative incoherence is limited neither to single words nor need be about words at all. My favorites from Freud recount reversed arcs of action, like the young man who, having boarded a train to his destination, gets off and absentmindedly re-boards for the trip back; and the senatspresident who gavels and declares a meeting "adjourned" even as he opens it. Our immediately triggered, first-order interpretations of "the other story" in these cases point to an acute need to avoid something. As for elaborated second and third order interpretations, it appears the more we know, the better we argue our case (e.g. as to why I forgot my brother's name), but competing hypotheses also multiply quickly—and each calls up other background assumptions.

A continuing concern remains: what should guide us in the rejection or discard of, not just these interpretations, but the simpler, first-order ones as well?

DISCUSSION

A century of analytic scholarship attests to a considerable store of clinical and intricate wisdom under the different theoretical paradigms. This essay returns to the question of common threads running through it all.[24] Ideas brought together here are neither novel nor unfamiliar, but articulate those proposed to be in play across all analytic

[24] But consider that we also share assumptions common to *all* talk therapies: that a suffering person seeks help from another, expecting benefit and understanding within that relationship. Frank, noting a common profile of training, arcane knowledge, social status, *and* the passionate investments of healers in their work, declared parallels between us all, from analysts to witch-doctors (1973). We, of course, claim greater specificity in understanding the complex sufferings of patients for whom we apply our craft.

practice. The aggregate, organized as to kind and function, are as follows. *Metaphors* over a given span of examined process, typify *recurrently thematic nodes* of a case, tied to key matters from the theatres of the personal and dyadic dynamics of treatment, and represent significant *content-centered* assumptions. In a different aspect, the metaphoric capacity functions as a *process-catalyst*, expanding the subsymbolic aspect of the treatment experience, and recursively stimulating this style of thinking. *The bond of safe company* comprises a family of experiences within the dyadic engagement, that functions as an obligatory *platform of protection* and *generative sine qua non of the process*. The phenomenon of ever-branching clusters of meaningful understandings, borne in extended treatment, represents both *process* and *outcome* features, and carries *diagnostic* value.

Becoming freer agents in given ways is a good *outcome* of treatment; consequently, *agency* markers *diagnose change* in a person's power to self-direct or fail, both in long-range, and momentary process. The other four narratively-cored assumptions proposed here generally relate to moments in the moving process. The *courage to bear anguish*, an aspect of agency, captures moments of progressive *change*. *Surprise* signals *change of perspective*. Clinical markers for *points of urgency* and *shifts in voice*, as for *narrative incoherence*, signal *when to intervene—or mark* the moment.

Out of the present study, other background assumptions come into view: 1) The *moral commitment of the frame* surfaces as surely commonly practiced—undergirding the bond of safe company, with the analyst as sentinel; 2) Both *rigidity*, as a recurring dark *diagnostic* sign, and 3) *Defensive configurations* are implied by the failures and retreats of the bond of safe company, and of agency and courage, and lie behind instances of

narrative incoherence and shifts in voice; 4) *Transference and counter-transference*, touched on here, need further expansion as *metaphors of the living relationship*.[25]

Capturing the broad pattern in this emerging patchwork of shared taken-for-granteds from a distance, just as magnetometers and deep radar mark the outlines of a buried Stonehenge or a city, may eventually suggest a simple *ur*-theory of clinical work. The ones collected thus far relate to only few aspects of diagnosis, assessment of change, and technique. If a fuller, basic schema emerged, it well might be that—within this level of discourse—it may not clarify the difference between psychotherapy and psychoanalysis, but underscore their underlying kinship. From such a psychodynamic cyborg, a purist would recoil in horror. Certainly, we might have instead examined and distinguished assumptions behind fundaments of the variant paradigms, such as the O in Bion, language in Lacan, the bedrock of badness/goodness in Klein, co-creation for relational analysts, and adaptation for ego psychologists. Each demands its own paper and expert. Nonetheless, what analytic clinicians find they *can* share and observe critically, and commit to future validation, promises more, it seems to me, for a return of psychoanalysis-as-treatment to its place in medicine.

BIBLIOGRAPHY

AINSWORTH, M. D. S., Blehar, M. C., Waters, E., & Wall, S., eds. (1978). *Patterns of Attachment: A Psychological Study of the Strange Situation*. Erlbaum: Hillsdale.

ALLISON, E. & FONAGY, P. (2016). When is truth relevant? *Psychoan. Q.* 85:275-303.

ALTER, I. (1996). On novelty and exploration in the analytic situation. *Psychoanal. Contemp. Thought* 19:611-620.

[25] Ultimately, I suspect, we should find that Wallerstein's original three proposals for common ground do after all reside within the corpus of practice, but require carefully revised descriptions for their clarification.

ALTMAN, R. (2008). *A Theory of Narrative*. Columbia University Press: New York.

ALVAREZ, A. (1992). *Live Company: Psychoanalytic Psychotherapy with Autistic, Borderline, Deprived, and Abused Children*. Routledge: New York.

ANGIER, N. (2017). A baby wails, and the world comes running. NYT: NY, 9/4/2017.

ARLOW, J. (1979) Metaphor and the Psychoanalytic Situation. *Psychoan. Q.* 48:363-385

BAILLY, L. (2009). *Lacan: A Beginner's Guide*. Oneworld Pub.: London.

BERGMANN, M.A. (2011). Reik's confession: construction or interpretation. *Psychoanalytic Review* 98:247-252.

BERNARDI, R. (2017). A common ground in clinical discussion groups. *Intl. J. Psychoanal.* 98:1297-1309.

BERNFELD, S. (1941). The facts of observation in psychoanalysis. *J. Psychol*. 12 289-305. Also in: *International Review of Psycho-Analysis* 12: 342-351.

BLACKER, K. H. (1975). Tracing a Memory. *J, Amer. Psychoan. Association* 23: 51-68.

BOESKY, D. (2005). Psychoanalytic controversies contextualized. *Journal of the American Psychoanalytic Association* 53:835-863.

BOESKY, D. (2013). What does the presentation of case material tell us about what actually happened in an analysis and how does it do this? *International Journal of Psychoanalysis* 94:1135-1143.

BOSTON CHANGE PROCESS STUDY GROUP. (2010). *Change in Psychotherapy: A Unifying Paradigm*. Norton: New York.

BOWLBY, J. (1958). The Nature of the Child's Tie to his Mother. *Int. J. Psycho-Anal.* 39:350-373.

BOWLBY, J. (1973). Attachment and Loss. *Int. Psycho-Anal. Lib.* 95:1-429. London: Hogarth Press & the Institute of Psycho-Analysis.

BORBELY, A. (2009). The Centrality of Metaphor and Metonymy in Psychoanalytic Theory and Practice. *Psychoanal. Inq.*, 29(1):58-68.

BORBELY, A. (2011). Metaphor and Metonymy as the Basis of a New Psychoanalytic Language. *Psychoanal. Inq.*, 31(2):159-171.

BRUNER, J. (1974). *Child's Talk: Learning to Use Language*. Norton: New York.

BUCCI, W. (1997). *Psychoanalysis and Cognitive Science: A Multiple Code Theory*. Guilford: New York.

CASTON, J. (1993). Can analysts agree? The problems of consensus and the psychoanalytic mannequin: I. A proposed solution. *Journal of the American Psychoanalytic Association* 41:493-512.

CASTON, J. (2007). Poetic closure, psychoanalytic termination, and death. *Journal of the American Psychoanalytic Association* 55:7-30.

CASTON, J. (2011). Agency as a Psychoanalytic Idea. *Journal of the American Psychoanalytic Association*. 59:907-938.

CASTON, J., GOLDMAN, R.K., & McCLURE, M.M. (1986). The immediate effects of psychoanalytic interventions. In: Weiss, J. & Sampson, H., & The Mount Zion Research Study Group. (1986). *The Psychoanalytic Process: Theory, Clinical Observation, and Empirical Research*. Guilford: New York, pp277-298.

CASTON, J., & MARTIN, E. (1993). Can analysts agree? The problems of consensus and the psychoanalytic mannequin: II. Empirical tests. *Journal of the American Psychoanalytic Association* 41:513-549.

CIVITARESE, G. (2016). Truth as Immediacy and Unison: A New Common Ground in Psychoanalysis? Commentary on Essays Addressing "Is Truth Relevant?" *Psychoanal. Q.* 85:449-501.

CIVITARESE, G. & FERRO, A. (2013). The meaning and use of metaphor in analytic field theory. *Psychoanalytic Inq*. 33:190-209.

COLES, R. (1965). On courage. *Contemp. Psychoanalysis* 1:85-98.

CROWELL, J.A., TREBOUX, D., & WATERS, E. (2002). The stability of attachment representations: the transition to marriage. *Developmental Psychol.* 38:467-479.

CSIBRA, G. (2009). Natural pedagogy. *Trends in Cognitive Science* 13:148-153.

CSIBRA, G. & GERGELY, G. (2006). Social learning and social cognition: the case for pedagogy. In: Johnson, M.H. & Munakata, Y.M., eds. *Processes of Change in Brain and Cognitive Development, Attention and Performance*. 21: 249-274.

DeWITT, K.N. (2007). The development of the scales of psychological capacities: A work in progress. In Bucci, W. & Freedman, N. From Impression to Inquiry: A Tribute to the Work of Robert Wallerstein. IPA Publications: London, pp67-81.

ERIKSON, E.H. (1972) Play and actuality. In: Piers, M. & Piers, M.W. (1972) *Play and Development*. Norton: New York.

FINK, B. (2004). *Lacan to the Letter: Reading Écrits Closely*. U. Minn. Press: Minn.

FENICHEL, O. (1941). *Problems of Psychoanalytic Technique*. Psychoan. Quart.: NY.

FERRO, A. (1999). *The Bi-personal Field*. Routledge: New York.

FINE, S. & FINE, E. (1990). Four psychoanalytic perspectives: a study of differences in interpretive interventions. *J. Amer. Psychoanal. Assoc.* 38:1017-1031.

FONAGY, P. (2017). The concept of epistemic trust: Can it help integrate attachment and psychoanalysis? Paper given at S.F. Center for Psychoanalysis, 1/9/17.

FONAGY, P., TARGET, M., GERGELY, G., ALLEN, J.G., & Bateman, A.W. (2003). The developmental roots of borderline personality disorder in early attachment relationships: a theory and some evidence. *Psychoanal. Inq.*, 23(3):412-459.

FREUD, S. (1900). *The Interpretation of Dreams*. Standard Edition, IV.

FREUD, S. (1901). *The Psychopathology of Everyday Life*. Standard Edition, VI.

FREUD, S. (1905). *Jokes and Their Relation to the Unconscious*. Standard Edition, VIII.

GARFINKEL, H. (1963). A conception of, and experiments with, "trust" as a condition of stable concerted interactions. In: Harvey, O.J., ed., *Motivation and Social Interaction*. Ronald Press: New York p.187-238.

GARFINKEL, H. (1967). *Studies in Ethnomethodology*. Polity Press: Cambridge.

GENETTE, G. (1980). *Narrative Discourse: Essay on Method*. Cornell U. Press: Ithaca.

GENETTE, G. (1988). *Narrative Discourse Revisited*. Cornell U. Press: Ithaca.

GREENSON, R. (1967). *The Technique and Practice of Psychoanalysis. Volume I.* Intl. Universities Press: New York.

GRICE, P. (1989). *Studies in the Way of Words*. Harvard University Press: Cambridge.

GRUNBAUM, A. (1984). *The Foundations of Psychoanalysis: A Philosophical Critique*. University of California Press: Berkeley.

GUTTMAN, S.A. (1987). Robert Waelder on psychoanalytic technique: Five lectures (1938). *Psychoanalytic Quarterly* 56:1-87.

HERITAGE, J. (1984). *Garfinkel and Ethnomethodology*. Polity Press: Cambridge.

HESSE, E. & MAIN, M. (2000). Disorganized infant, child, and adult attachment. *J. of the American Psychoanalytic Association* 48:1097-1127.

HOROWITZ, L.H., SAMPSON, H., SIEGELMAN, E.Y., GOODFRIEND, J., & WEISS, J. (1978). Cohesive and dispersal behaviors: Two classes of concomitant change in psychotherapy. *J. Consulting and Clinical Psychology*. 46:556-564.

JACOBS, T. (2008). On courage. *Psychoanalytic Psychology* 25:550-555.

JAFFE, J. & FELDSTEIN, S. (1970). *Rhythms of Dialogue*. Academic Press: New York.

JAFFE, J., BEEBE, B., FELDSTEIN, S., CROWN, C.L., JASNOW, M.D. (2001). *Rhythms of Dialogue in Infancy: Coordinated Timing in Development*. Mgrs. of the Soc. for Research in Child Development, Serial #265, V. 66, No. 2

KERNBERG, P., CHAZAN, S., & NORMANDIN, L. (1998). The Children's Play Therapy Instrument (CPTI): Description, development, and reliability Studies. *J. of Psychotherapy, Practice, and Research*. 7:196-207.

KRIS, A.O. (1982). *Free Association: Method and Process*. Yale U. Press: New Haven.

KOHUT, H. (1970). On courage. In: STROZIER, C.B. & KOHUT, E. *Self-psychology and the humanities*, p5-50.

LAKOFF, G. & JOHNSON, M. (1980). *Metaphors We Live By*. U. Chicago Press: Chic.

LEUZINGER-BOHLEBER, M., BURGIN, D. (2003). Pluralism and unity in psychoanalytic research: Some introductory remarks. In: Leuzinger-Bohleber, M., Dreher, A.U., Canestri, J., Eds. (2003). *Pluralism and Unity? Methods of Research in Psychoanalysis.* Intl. Psychoanal. Assn.: London.

LEVENSON, E.A. (1983). *The Ambiguity of Change*. Basic Books: New York.

LEVENSON, E.A. (1988). In pursuit of the particular. *Contemp. Psychoanal*. 24:1-18.

LEVINE, S. (2006). Catching the wrong leopard: Courage and masochism in the psychoanalytic situation. *Psychoanalytic Quarterly* 75:533-556.

LUBORSKY, L. & MINTZ, J. (1974). What sets off momentary forgetting during a psychoanalysis? *Psychoanalysis and Contemporary Science*. 3:233-268.

LUBORSKY, L. & MINTZ, J. (1996). The context for momentary forgetting. In: Luborsky, L. (1996). *The Symptom-Context Method: Symptoms as Opportunities in Psychotherapy*. The Amer. Psychol. Association: Washington, D.C. pp31-62.

MAIN, M. (2000). The organized categories of infant, child, and adult attachment. *J. Amer. Psychoanal. Assn.*, 48(4):1055-1095.

MacINTYRE, A. (1984). *After Virtue*, 2nd ed. U. Notre Dame Press: Notre Dame.

MARMOR, J. (1955). Validation of psychoanalytic techniques. *Journal of the American Psychoanalytic Association* 3:496-505.

MODELL, A.H. (2003). *Imagination and the Meaningful Brain*. MIT Press: Cambridge.

MODELL, A.H. (2011). Not Even Wrong. *Psychoanal. Inq.*, 31(2):126-133.

MORREALL, J. (1983). *Taking Laughter Seriously*. SUNY Press: Albany.

PIEL, B. & SCHREIBER, G. (1994). On psychoanalysis and non-linear dynamics: The paradigm of bifurcation. *Brit. Journal of Med. Psychology* 67:209-218.

REIK, T. (1937). *Surprise and the Psycho-Analyst*. New York: E. P. Dutton and Co.

RICOEUR, P. (2007). *From Text to Action: Essays in Hermeneutics, II*. Northwestern University Press: Evanston.

SANDLER, J. (1960). The background of safety. *Intl. J. Psychoanal.* 41:352-365.

SANDLER, J. & JOFFE, W.G. (1968). Psychoanalytic psychology and learning theory. In: *The Role of Learning in Psychotherapy*. Ciba: London, Churchill, 274-287.

SCHUTZ, A. (1962). Common sense and the scientific interpretations of human action. In: *Collected Papers*, vol. 1. 3-47.

SKURA, M.A. (1981). *The Literary Use of Psychoanalytic Process*. Yale Univ. Press:

SMITH, H.F. (1995). Analytic listening and the experience of surprise. *International Journal of Psychoanalysis* 76:67-78.

SMITH, H.F. (2001). Obstacles to integration: another look at why we talk past each other. *Psychoanalytic Psychology*. 18:485-514.

SMITH, H.F. (2003). Can we integrate the diverse theories and practices of psychoanalysis? *J. Amer. Psychoanal. Assn.* 51*S* 127-144.

SMITH, H.F. (2005). Dialogues on conflict: toward an integration of methods. *Psychoanal. Q.* 74:327-363.

SMITH, H. (2008). Six inventions on unconscious theory. *Psychoanal. Inq*. 28:231-55.

STEPANSKY, P. (2009). *Psychoanalysis at the Margins*. Other Press: New York.

STEMBERGER, J.P. (1992). The reliability and replicability of human speech error data: a comparison with experimentally induced errors. In: Baars, B.J. (1992). *Experimental Slips and Human Error*. Plenum Press: New York, pp195-215.

STERN, D.B. (1990). Courting surprise: Unbidden perceptions in clinical practice. *Contemp. Psychoanalysis* 26:452-478.

STRENGER, C. (1991). *Between Hermeneutics and Science: An Essay on the Epistemology of Psychoanalysis*. Int'l. U. Press: Madison.

TAERK, G. (2002). Moments of spontaneity and surprise: The nonlinear road to something more. *Psychoanalytic Inquiry* 22:728-739.

TUCKETT, D. (2008). Reflection and comparison: some final remarks. In: Tuckett, D., Basile, R., Birksted-Breen. D., Bohm, T., Denis, P., Ferro, A., Hinz, H., Jemstedt, A., Mariotti, P., Schubert, J. Eds. (2008). *Psychoanalysis Comparable and Incomparable*, Routledge: London (p.243-261).

VOTH, H.M. (1970). The Analysis of Metaphor. *J. Amer. Psychoanal. Assn.*, 18:599-621

WALLERSTEIN, R.S. (1992a). Psychoanalysis: the common ground. In: Wallerstein, R.S., ed. (1992). *The Common Ground of Psychoanalysis*. Aronson: Northvale.

WALLERSTEIN, R.S. (1992b). Psychoanalytic pluralism. in: Wallerstein, R.S., ed. (1992). *The Common Ground of Psychoanalysis*. Jason Aronson: Northvale.

WALLERSTEIN, R.S. (1992c). Psychoanalytic pluralism; the resolution of the issue? in: Wallerstein, R.S., ed. (1992). *The Common Ground of Psychoanalysis*. Jason Aronson: Northvale.

WALLERSTEIN, R.S. (2005a). Will psychoanalytic pluralism be an enduring state of our discipline? *Intl. J. Psychoanal.* 86:623-626.

WALLERSTEIN, R.S. (2005b). Dialogue or illusion? How do we go from here? *Intl. J. Psychoanal.* 86: 633-638.

WALLERSTEIN, R.S., DeWitt, K., Hartley, D., Rosenberg, S.E., Zilberg, N.J. (2000). *The Scales of Psychological Capacities*. University of California, San Francisco.

ZETZEL, E.R. (1949). Anxiety and the capacity to bear it. In: Zetzel, E.R. (1970). *The capacity for emotional growth*, p33-52.

ZETZEL, E.R. (1965). On the incapacity to bear depression. In: Zetzel, E.R. (1970). *The capacity for emotional growth*, p82-114.