Personalizing Psychoanalysis: Notes on Psychoanalytic Theory, Internalization, and History

Jonathan Dunn

Introduction

This paper is primarily about theory, or, more accurately, my theory of psychoanalytic theorizing. We theorize outward from certain "core" concepts (basic assumptions about human nature and mental life) that naturally mesh with our individual characters and reflect what's most important and meaningful to us. The more considerations we integrate into our theoretical center, the more comprehensive and thus effective our theory will be. Parsons (2000, 2006) writes that our theories will mean little to our patients if they feel impersonal to us. I take this to mean that personally communicating theory that relates to our everyday lives and clinical work, will stimulate others to identify with theories that harmonizes with their own. Finding ourselves in our theories, and our theories in our selves, is fundamental to my theory of theorizing. I call this process *personalizing theory.*[1]

My thesis coordinates with the paper's design – ten separate theoretical vignettes (plus an

[1]See Kachele's (2010) discussion of 'core" psychoanalytic concepts. It is also important to note that in this paper I'm considering theory in the widest sense and do not specify the different kinds of analytic theory – metapsychological, clinical, technical, etc. Doing so in the future may refine my discussion, but for now blending them together is secondary to my over-riding purpose and inquiry.

epilogue), most of which directly illustrate personalizing theory, while a few others elaborate some core concepts that converge on this theme. I present them not as objective principles but instead as meditations that readers may personally relate to in their own way. Some of the vignettes engage analytic ideas from angles and contexts outside psychoanalysis, such as the arts, education, and athletics. Relating psychoanalysis to other life activities and ways of thinking and creating, clarifies both its subjective and elastic quality. Reasoning why personalizing theory is necessary is woven into each vignette.[2]

I

Personalizing Theory and Internalization

> *The antithesis between the inner and outer, subject and object remains, above all, sovereign in our intellectual activity and creates for research the basic situation which no one can alter.*
>
> – Freud

> *To recognize that the object of our feelings, needs, actions, and thoughts is actually another subject, an equivalent center of being, is the real difficulty.*
>
> -- Jessica Benjamin

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[2]I'm using "psychoanalyst," "analyst," "analytic therapist", as well as "analytic process," or "clinical process," and "analytic therapy" or just "therapy," interchangeably, and consider psychoanalysis and psychoanalytic psychotherapy on a continuum rather than as distinct. This debate goes back to Freud comparing the "copper of psychotherapy to the gold of psychoanalysis," and relates to how to define psychoanalysis in general (see Wallerstein, 1969; Fosshage, 1997; Kernberg, 1999; Eisold, 2005; Blass, 2010; Busch, 2010; Widlocher, 2010; Kachele, 2010; and Aron & Starr, 2013, for different opinions on this subject).

My subjective, and subjectifying, emphasis can engender a chaotic "anything goes" attitude, but we have no choice but to take that risk. For analytic theory has clinical value only so far as it embodies who we sincerely and authentically are. Personalizing theory stimulates our desire to know more. In what follows is my exploration of why this is so.

Our theories embody our analytic sensibility, attitude, and overall "clinical presence" that colors all our verbal and non-verbal communication (see Loewald 1975; and Markman 2017 on clinical presence). *How* we voice our interpretations -- our pitch, rhythm, inflection and tone – conditions the way they are experienced and considered by our patients. My point that analysis works best when it's personally aligned is subtler than it appears. Because we're always somewhat alienated from ourselves, we sometimes lose our confidence and start sounding (and behaving) like one of our analysts, supervisors, teachers, or text books. Distance from ourselves creates distance from our patients. My paper may be read as a counter to such an outcome.

Unlike any other profession, psychoanalysis advances by exploring our desire to do its work. We naturally strive to embody our theory, not just learn it academically. When embodiment envelops intellectual comprehension, our theories become our own discovery. They reflect and communicate who we are, not just what we think. We become music makers not simply note

players.

My thinking here poses the following clinical questions: *How do we instill our ideas "into" the minds of our patients -- inspirit our humanity and personal experience -- in such a way that our patients genuinely transform and integrate what they take in from us, into their own sense of self and self-image? How does an experience that originates in us become an original experience for someone else?* These questions entail the psychodynamics of internalization – absorbing aspects of the external world into ourselves. Internalization is the mind at work, and not simply an aspect of it (Lear 2005). It integrates novel experience into psychic structure and functioning, making our theoretical orientations more comprehensive. Why certain theories don't appeal to us also becomes clearer. The kind of psychoanalyst we cannot or don't want to be – the negative of our psychoanalytic identity -- articulates in our minds.

Psychoanalysis is both an independent body of knowledge and an activity in the world. Theorizing for clinical purposes actualizes its therapeutic intent and social meaning. Doing so is culturally-conditioned. Each psychoanalytic generation (and each individual analytic therapist) must therefore establish a clinical style and analytic identity of their own. We do this alone and in groups. It's what I am trying to do in writing this paper and what you are trying to do in reading it.

II

Personalizing Theory as Relational Connection

> *The life that impacts on sense and feeling threatens at times to overwhelm us with complexity and conflict. At such times we have to take distance. We harness personal problems with generalities... But behind the abstractions lurks a shadow. Only by a sudden metaphor, a wry twist of phrase, does the reader sense that what he reads was wrought in conflict and sometimes anguish.*
>
> – Allen Wheelis

Psychoanalytic theory arises from a desire for self-knowledge. Personally identifying with theory is intrinsically problematic, as I elaborate in following sections, but, as I stated above, we have no better choice. Clinical originality born from sincerity generates the levels of intimate clinical involvement that we aspire to. "No technical display but inner sincerity is the core of analysis," writes Theodore Reik (1952).

Analytic sincerity generates emotionally-rich introspection. Only by expressing our theories from our hearts and souls can we inspire such personal self-expression in our patients (see Bettelheim [1982]; Kennedy [2014], on the "soul" in psychoanalysis). Our clinical presence becomes *actual* ("existing in the present moment"), and our clinical impact becomes *real* ("not pretended" [both definitions from Webster's X]). Consider the manner in which

singer/songwriter Bob Dylan internalized traditional American folk songs, created before he was born and within a different cultural milieu from his own. His ability to personalize their spirit, to "fit history through the needle's eye of the self" (Cunningham 2018), mobilized an intimate bi-directional connection with his audience. Dylan (2004) recalls:

> I'd either drive people away or they'd come in closer to see what it was all about...With me, it was putting the song across....Folk songs were the way I explained the universe, they were pictures and the pictures were worth more than anything I could say. *I knew the inner substance of the thing. I could easily connect the pieces.* Most of the other performers tried to put themselves across, rather than the songs, but I didn't care about that (p.18 emphasis added).

To my mind, Dylan's impact and appeal springs from expressing his emotional "truth," rather than from impressing (ie., imposing himself upon) his audience. His control came from sincerity not coercion (if he drives his listeners away, so be it). Audiences feel free in these circumstances to internalize artistic productions on *their* terms, according to *their* truth. By unselfishly putting himself "behind" his songs, Dylan makes them worthy of passionate contemplation within a reliably bounded intersubjective engagement. Doing so paradoxically emboldens his personal presence and enhances his power of persuasion.

Dylan transformed each of his songs' objective, free-standing existence into subjective statements concerning his experience of life. Personalizing our theory as Dylan does his songs makes our clinical activity subjective statements as well. Doing so unselfishly guards against using theory to dictate and possess. The narcissistic investment we have in our theories

determines the impact they have on our patients.

We hope to affect our patients as artists such as Dylan affects their audiences. We want our feelings and ideas to reach them. Only our sincere, original, and authentic self-expression will touch their hearts and minds and lead them back to themselves. But personalizing theory isn't as simple as I've been presenting it. Analytic process needs more than sincere self-expression and relational immersion. Maintaining a private self is also part of the job. The analytic situation is both communal and alienating at the same time. Contradictions such as these reflect a fault line in all psychoanalytic work. It's hard to imagine a theory otherwise that strives to capture the paradoxical quality of mental life and psychic conflict (Ghent 1992). The following section considers the alienating dynamic of personalizing theory more specifically.

III

Personalizing Theory: The Analyst's Second Self and the Problems of Idealization

The "role" of analytic therapist requires a private self that is separate from the patient's. But a clinical role doesn't necessarily mean false relating (Newton 1971). Consider how a dramatic actor can authentically express the emotional reality of a character imagined by the playwright, who is a separate person from the actor. The actor elicits genuine feelings in her audience precisely because she genuinely expresses them through the character she's portraying. Real feelings are channeled through theorized acting techniques, methods, and goals. Controlling

this mental split allows the actor to communicate emotional truth while also knowing she's not in her "real" life. Actors and analysts "play" with reality in similar ways. Constantin Stanislavsky's (1936) based his ground-breaking "method acting" on this dynamic, which he created in the wake of Freud's theories of the unconscious (Freed 1964): "The actor must fit his own human qualities to the life of this other person, and pour into it all his own soul". On this point, Roy Schafer's "*second self"* comes to mind. He writes that analytic therapists enact a "kind of second self ...[that] is not and cannot be discontinuous with one's ordinary personality; yet it is a special form of it...It is within this form that one expresses his or her humanity analytically" (1982).

Personalizing theory generates the "psychic space" Schafer's *second self* suggests. Our work is paradoxical; we stay acutely present and connected in clinical interaction while simultaneously constraining and holding ourselves back. Doing so incites primal desires for greater contact and communication -- to evolve outwardly so to fill the "space." The remaining gap creates a persistent hope and seeking out for something better in the future (the psychic force and direction of Freud's Eros – see vignette **VII).** Emotional meaning in the intrapsychic and transference/countertransference dynamics emerge and are co-constructed in this context. Analysis heals in this way, assuming, that is, analyst and patient stay in the current experience while connecting it with the patient's present and past needs, wishes, fears, fantasies, conflicts, frustrations, and terrors. Negotiating their different desiring positions and purposes

determines the healing quality of the process (Friedman 2009; Wilson 2013).

We also use theory to falsify and hide. One way is by exaggerating the authority of theoretical knowledge. Idealizing a beautifully written article, or a gifted charismatic presenter, for example, is as irresistible as it is common. We all do it, we all need to do it. While idealization constitutes our "ego-ideals" and "ideal selves" from which we form healthy ambitions (Lampl-de Groot 1962; Blos 1974), idealization holds us back when taken too far. Its trouble concerns how our self-image in relation to the idealized other unconsciously inflates beyond human limits. Here a grandiose attitude shapes our relationship to theory. It becomes ideological rather than interpretative – a personal strait-jacket rather than a means of personal self-expression. Brittle certainty and either/or thinking presides over critical evaluation, and maintaining idealizations motivates theorizing more than curiosity and desire to help. Our communication becomes subtly impersonal, constrained, and coercive.

IV

Personalizing Theory and Psychoanalytic Pedagogy

The radically personal nature of our work complicates analytic pedagogy unlike any other profession. Its academic grasp differs from its subjective experience, where it becomes an idiosyncratic expression of our characters, rather than a free-standing body of knowledge. Traditional "banking models" (Freire 1973), in which teachers deposit information into

students, lose this subjective, and subjectifying, dimension of our work. They don't adequately contend with analysis' experiential/cognitive, self/other, and theory/ practice divide – that is, its contradictory "mixed discourse" (Ricoeur 1970; Foucault 1984; Robinson 1993). Psychoanalysis should be taught academically, but not only, in other words. Jeremy Denk (2013) teaches music students to "incite their imagination about what's behind and between the notes, what could never be written down in a score". Shouldn't we be developing specific *psychoanalytic* ways of doing this in ways that are germane to our field (Dunn 2013)?

Outstanding analytic theorists help us to find ourselves in our theory and our theory in ourselves. But subtle idealization in the process obscures the distinction between imitation and genuine self-expression. Who decides which is which has vexed our profession from its beginning. Evaluating professional competency and candidate progression has never been clear. Laufer (2004) believes a candidate's progress should be evaluated "on how far he has allowed his understanding to become a part of his own knowledge through the link to his own emotional experience." But again, who decides? Perhaps the idiosyncrasy of psychoanalysis defies adjudication by an external body?

Only by integrating analysis' intellectual and emotional, objective and subjective, components,

can teachers inspire students to seek their own theoretical perspectives and ways of practice.[3] Here I agree with Lacan that psychoanalytic learning and identity can only be "internally mandated" by the analyst him or herself, although, despite its correct pedagogic orientation, Lacan's self-selection "pass" proved unsustainable (Turkle 1978).

Managing the tension created by the two opposing mental functions and perspectives of analysis – objectivity and subjectivity -- spurs analysis' creativity and insight (Arendt 1961). I will elaborate this tension in vignette **VI**. But first I take another look at the problem of personalizing theory and its idealization from a different angle.

V

Personalizing Theory, Idealization, and the Analyst's Character

Understanding another's mental life is a critical component of analytic treatment. But full comprehension is impossible. Our needs, desires, and fears invariably bias our view, making our interpretations always partial and provisional. Franz Alexander (1960) says we can neither

[3]Korner (2002) writes: "In our seminars on psychoanalytic concepts... we always convey something of our psychoanalytic attitude … [if taught well] knowledge is condensed to the solid state which becomes liquified … into one's own personal experience." Also see Power (2001); Britzman (2009); and Skorczewski (2008 & 2010).

understand nor help our patients as much as we (or they) wish we could. Despite the help analytic therapy provides, we invariably struggle with a sense of defeat. Theorizing provides some relief, but only for a time. In the end, theories are often fascinating ideas that offer exciting starting points to imaginatively "enter" into another's psychic reality for the better (see Levy and Inderbitzen [1990] on "analytic surfaces"). But our theories are just ideas all the same and always falls short of our wishes and needs.

Idealizing our theories (and our theorists) is seductive nonetheless. We all do it, we all fall in love with our thinking and our thoughts, albeit with varying effects (and, of course, with oscillations of devaluation). Idealization is costly. Its intrinsic certainty negates wisdom and kindness without which our theories are clinically useless. Good analytic therapy obligates humility and doubt. Embracing ambiguity opens our minds to what's novel and unknown. Acknowledging our deficiencies ethically grounds our profession and, if managed well, advances understanding and clinical progress (Wilson 2006). "Analytic practice, writes Seligman, "...demands that we tolerate uncertainty; if we cannot, or if our language discourages such tolerance, a narrow and constraining focus may limit the expansive potentials of the analytic setup" (2018).

In his article, *What the Analyst Does Not Hear* (1999), Lee Grossman asks how to best

understand the role of the analyst's *ignorance.* As with Seligman, Grossman says the "character trait" of certainty reflects a false belief in an ultimate authority and a final reference point. Grossman (2014) and Jane Kite (2008) posit that theories of technique are rationalizations of the analyst's character -- reflections of his or her subjectivity rather than of objective truth. Kite sees theories "dissolving" into the analyst's personality (as is generally accepted, Kohut's patient, Mr. Z, was Kohut himself). Stephen Purcell (2004, 2014) notes how theory can be used to deny clinical failures and how it can create problematic countertransference and restrict the emotional experiences that patients need to develop new psychic structure. Rather than our theorizing, Purcell believes successful analysis revolves primarily around the love developed between the analytic couple (which is the subject of vignette **VIII)**.

> *We need...a practical theory of analytic technique that takes account of the inherent subjectivity of every aspect of an analyst's activity.*
>
> – Renik

Grossman, Kite, and Purcell circle around the analyst's narcissism. Mitchell Wilson (2003, 2013), in my view, confronts it head on. He believes that analyzing resistances always involves the analyst's unacknowledged desires he's imposing on the patient. These "conditions of satisfaction" are operative in every analysis regardless of the analyst's theory, and they relate to the analyst's needs for validation rather than to his or her concepts and ideas. Unidirectional interpretations, such as, *"he projected his displeasure into me*," or, *"I'm containing unwanted parts of her*," negate consideration of the analyst's desiring state of mind. Wilson's clinical

perspective addresses Renik's challenge -- namely, follow analytic process by considering first how our desires are provoking our patient's reactions to us. The analyst's *selfish use* of theory is more fundamental than the theory itself.

Ideally we use theory for genuine self-expression rather than to dictate and control. At a clinical seminar years ago, Antonino Ferro told our gathering that theorizing when working with patients signals a "breakdown in the field." We're now grasping for a patient we've lost contact with and are primarily using theory to reclaim a sense of emotional stability. Personalizing theory in a non-idealizing and nonintrusive way moderates such self-centered clinical functioning. We rationalize our mistakes less often and sort out our contributions from those of the patient with less ardor and confusion.

As noted above, psychoanalytic theory encases its objective orientation within its subjective, experiential foundation. Harmonizing these mental functions creates an irresolvable tension in analytic work and complicates our efforts to personalize our theories. The challenge this tension creates is the topic of the next vignette.

VI

Personalizing Theory and the Mixed Discourse of Psychoanalytic Theory

Analytic therapists are forever trapped in the "mixed discourse" of psychoanalysis (Ricoeur 1970; Foucault 1984; Robinson 1993). Our theorizing *objectifies* patients as external, separate objects. But doing so wrestles endlessly with the intersubjectivity, mutual identification, and bi-directionality of clinical practice. Formulating another's psychodynamics establishes *separation and distinction;* synching up emotionally -- that is, non-cognitively and experientially -- creates *identification and sameness*. The former relies on consciously worked-out, secondary process thinking, from which mental life appears *structured;* the latter derives from pre-or-unconscious, non-symbolized emotional experience that flows with analytic *process* that's sensual, intuitive, unformulated, and non-verbal.

Formal theorizing and experiential practice are different mental functions -- the predictability of constancy on the one hand; the uncertainty of mobility on the other (ie., Freud's analytic mind-set of *Gleichschwebend* -- "poised attention with freely floating, revolving circular motion" [Reik 1948). We want to know how the mind works both as a mechanism and as a relational dynamic. Our need for each way of knowing -- declarative and procedural -- produces an

intractable dilemma.[4]

Ric Almond (2003) notes the "holding function" of theory that keeps us from getting overwhelmed by the multiplicity and confusion of psychic life. But being "held" by theory is also being held in one place, impeding our relational flexibility and openness to surprise.[5] Clinical reality is so much more precarious and complex than any theory can describe "Over and over, I am impressed by how the world categorized by theory is so easily finessed into yielding greater clarity than the world categorized by practice, which with dispatch humbles us when we regard matters as definitive" (Wilson 2004). Wilson suggests that improvisation is as central to personalizing psychoanalytic work as any art form. Consider how Jazz musician John Coltrane's struggle to blend harmonic structure with moment-to-moment spontaneity, echoes our theory/practice quandary as well:

> [U]nfortunately I never lose my way. I say unfortunately, because what would interest me greatly is to discover paths that I'm perhaps not aware of. My phrasing is just a simple extension of my musical ideas, and I'm happy that my technique allows me to go very far in this area, but ....I 'localize', which is to say that I think always in a given space...The harmonies have become for me a kind of obsession, which gives me the feeling of looking at music from the wrong end of a telescope (in Ratliff 2007).

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[4]See Sandler (1983); Stern (1989, 2012); Pine (2001, 2011); Fonagy (2003); Wilson (2004); Reeder (2004); Lear (2005); and Rangel (2008), on the theory/practice split.

[5]Steve Goldberg (1991,1994) discussed this effect of theory in terms of the life histories, and the theories of pathogenesis, that patients bring to therapy (also see Mitchell Wilson's [1998] critique of theoretical narratives).

Coltrane's metaphor – *"from the wrong end of a telescope"* – captures our clinical challenge. We hope theory creates new clinical pathways, and in certain circumstances it does. But we sometimes also unwittingly use theory to *"unfortunately never lose our way*," for opening ourselves up to unknown mental life incites trepidation and reluctance. Terror of getting lost is the price we pay for creating unforeseen insights and interpersonal experiences. Like Coltrane and his music, for us *"localizing"* analytic theory confines our clinical experience and process to what's expected and already known, making self-exploration repetitive, tired, and rote.

Absorbing another's psychic distress is difficult and demanding work. Falling short of our ideals and struggles with our self-esteem invariably arise and avoiding full personal clinical involvement by localizing theory can't be helped. Our narcissistic investment in our theories – the dynamic of their personalization -- determines our ability to put them to good (or not so good) clinical use. The nature of their internalization is key to how well they mesh with who we are. I explore this idea further in the following vignette.

VII

Eros, Internalization, and the Bi-Directionality of Analytic Therapy

> *A sign of health in the mind is the ability of one individual to enter imaginatively and accurately into the thoughts and feelings and hopes and fears of another person; also to*

allow the other person to do the same to us.

– Winnicott (cited in Phillips &Taylor 2009)

Freud's concepts of the human life and death instincts, Eros and Thanatos (1920), comprise his most comprehensive elaboration of psychic internalization. Put simply, Eros (love of all kinds) opens up to and creates life, while Thanatos impedes life and closes it down.[6] Both are dialectically related, interdependent psychic forces that we balance according to each analytic relationship.[7] My paper focuses on the clinical role of Eros. It embodies our innate desire to attach to and integrate others in ways that continue and enhance life. Eros and other elements of Freud's instinct theory is how he grounded mental life in the body, and where his theory of psychic ontogeny, development, and functioning meets Darwin's (Draenos 1982; Ritvo 1990; Dunn1993).

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[6]American psychoanalysis considers the idea of a death instinct as either a misguided biological theory or wild philosophical speculation. However, my reading of Freud's instinct theory differs. For him, our instincts are the psychological *result* of our biological nature. They form from environmental conditioning of constitutional factors over time (Fenichel 1944). From a psychoanalytic (psychological) point of view, our instincts are "sediments of experiences from a long line of ancestors" (Freud 1911) ... "precipitates of the effects of external civilization... which [has] brought about modifications in the living substance" (Freud 1915). Biological death has become part of our psychic tissue so that "non-satisfaction...is the necessary consequence of certain peculiarities which [our instinctual endowment] has assumed under the pressure of culture" (1912).

[7]See Ogden (1986) and Hoffman (1994) on the dialectical nature of psychoanalytic theory.

Freud initially theorized sexual desire as libido. Later, Eros's genital meaning included a sensual propensity to "bind together...and establish even greater unities" (1940, p.148), what cognitive psychologist, Steven Pinker (2014), calls "the mind's infinite combinatorial power" (p.8). Eros's incorporative dynamic counters our eventual biological (material) dissolution. "Love is not time's fool," wrote Shakespeare: "Eternal love in love's fresh case weighs not the dust and injury of age" (Sonnet 8 in Booth 1977).

Eros fuels self-development and sense of self by propelling us out and into the world, as a means to open ourselves up to new experience. What we internalize and identify with – make part of ourselves -- changes who we are. Describing his infant daughter's emerging self in his novel, *Spring*, Karl Ove Knausgaard (2016) poetically captures Eros's drive and direction:

> You grow so slowly that no one notices, for first you grow outwards, by gripping and holding on to things around you with your hands, your mouth, your eyes, your thoughts, thereby bringing them into being, and only when you have done this for a few years and the world has been constituted do you begin to discover all that grips you, and you grow inwardly, too, towards yourself.

Eros's psychic manifestations generate life-enhancing relational engagement. These include our kindness and compassion, cooperation and concern, empathy and understanding, gentleness and support, encouragement and inclusion, nurturing and protection, inspiration and interest, appreciation and gratitude, generosity and trust, courage and forgiveness,

intuition and identifications, curiosity and wonderment, hopefulness and joy, imagination and creativity, introspection and grieving, and tolerance and wisdom. These qualities flow silently outward through our bodily gestures and our words. They shape the sensual subtleties of human communication from which an affirmative clinical "presence" may be established (see Loewald 1975; and Markman 2017 on clinical "presence").

The intrapsychic-relational dynamics of therapeutic action spring from Eros. We want our patients to internalize our clinical activity into their own voice and self-image. They must authorize their own treatment for it to work. But analytic therapy is also bi-directional: internalizing our patients spurs their internalization of us.[8] This reciprocal influence between the analytic couple is the basis of Enrico Jones's (2000) research into all types of analytic therapies, which found repetitive "mutually influencing interactions...[to be a] fundamental aspect of [all their] therapeutic action."

Internalizing, and being internalized by, another person is an act of love. We do this in different ways with different people, according to the context and type of relationship. Eros organizes

[8]The Lacanian "duel relation" that Mitchell Wilson (2013) discusses is another example of the bi-directional dynamic, but one in which the analytic couple is stuck.

the loving dynamics in clinical psychoanalysis and the force of love has no equal in both its power of personal self-expression and interpersonal connection.

VIII

Personalizing Psychoanalysis and Love

Freud (1974) wrote to Jung that love is the great teacher and that psychoanalysis is essentially a cure through love. While analytic patients need more than love, Eros's power to open and unify the mind is essential. Freud's term for erotic transference was actually "transference love" or the "love transference" (Person 1993). For Balint (1936), psychoanalysis came down to "less sadism and more love" (p.215), whereas Leo Stone (1961), from the New York Psychoanalytic Institute, considered a "therapeutic form of love" as one of the primary conditions of psychotherapy in general. Loewald (1970) equated love for the patient with respecting her autonomy and freedom, and, in her collected papers entitled *The Courage to Love* (1944/1970), Edith Weigert noted the "healing potentialities of the creative Eros."

In his classic paper, *Oedipal Love in the Countertransference (*1959/1965), which Sam Chase introduced me to during my candidacy, Harold Searles forthrightly discusses the clinical significance of the analyst's love. More specifically, he considered love an "optimal *background* feeling in the analyst" (ibid, my emphasis). How could any psychotherapy be personal enough without some kind of love developing between the participants? In this regard, French

psychoanalyst, Sacha Nacht (1962), emphasizes the connection between patients' unconscious perception of their analyst's feelings towards them and how they internalize interpretations. These authors make evident that relating clinical work to abstract theorizing on the level of Eros concerns the emotional atmosphere of the analytic relationship, initiated by the analyst's attitude, sensibility, and presence.

Love and all other affective interaction between the analytic couple registers initially in physical terms. We're fundamentally embodied creatures, so our non-conscious language of "sensory aliveness" anchors our communication. Meaning is embedded in our senses and our bodily experiences channel our perceptions of reality. Physical movement is the "plainest and most transparent of all languages," writes Gladwell (2006).

The physical basis of psychoanalysis dates with Freud's (1926) concept of the ego (or self) as first and foremost a "body ego". Later, Didier Anzieu (1979) and Riccardo Steiner (1987) elaborated how resonance and intonative patterns of the mother's voice effects the infant's self-development. Steiner mentions Ivan Fonagy's "language of our muscular apparatus", which concerns communication via facial expressions and body gestures (p.265). On this point, Ogden (1997, 1998) and Lear (2005) discuss how the sensory quality of *how* we speak to patients conditions their understanding of *what* we say.

Attending to the sensual body in psychoanalytic therapy is foundational. Here I ask: how do we best integrate – and clinically "use" -- our bodily experiences in our clinical work? I try to address this question in the next section.

IX

Personalizing Theory and the Physical Basis of Psychoanalysis

> *So it still seems as if one has to create one's own body in some way by attending to it from the inside. As if by meeting 'soul' and 'body' something new is created, something quite different from the body as used just for satisfying one's instincts. This deep source of something, all its cells taking part both as being fed by one's awareness of them and as themselves feeding, being sources of food, of psychic nourishment.*
>
> – Marion Milner

Henry Markman (2018) and Peter Goldberg (2012, 2018) discuss how the analyst's physical experience, in all its forms and sensory channels, but particularly music, shapes analytic process. Markman ties our bodily tone, movement, and gesture to emotional connection and clinical presence: "The analyst's embodied attunement is a kinesthetic sensing of others, knowing their rhythm, affect and experience, as carried by the body." Goldberg (2012) similarly writes that our "sensory engagement constitutes a distinctive, continuous active dimension of the analytic encounter; that its vicissitudes [deserve] "attention in their own right; and that dysfunction at the level of sensory engagement requires attention *at the sensate level.*"

Stephen Seligman's (2018) developmental/relational perspective critiques Freudian-based instinct theories of the body as too narrowly focused on "presocial...bodily zones or arbitrarily privileged physical states." He adds:

> The body sense and the sense of self-with-others are fundamentally intertwined, evolving in each family and taking on the various constraints and opportunities that are offered in particular social situations and historical moments.

The body in psychoanalysis has a history. Theodore Reik (1948) noted that the analytic relationship elicited "certain vocal modulations... particular pitch, timbre of voice [and] speech rhythm, which we do not consciously observe...[attuning himself to] the "variations of tone, pauses, and shifted accentuations...nuances of smell and peculiarities of touch...that accompany the coarser or stronger conscious sense-perceptions as overtones accompany a melody." Winnicott was as body-focused as Reik. "The True Self", he writes, "comes from the aliveness of the body tissues and the working of the body functions... including the heart's action and breathing...the summation of sensory-motor aliveness" (in McDougall).

Anchoring psychoanalysis in the body illuminates its personal nature. Turning it into an intellectualized procedure obscures its idiosyncratic spirit and meaning. Winnicott (1960) argued against this very hyper-intellectualism in his era, writing that: "The spontaneous gesture is the True Self in action." And Reik (1952), in his time, had the same criticism: "Explaining

results of depth psychology obtained in a purely intellectual way has very restricted value and effect....[it] serves as an excellent cover for lack of real psychological understanding, [for] the self is still the wealthiest mine of psychological discovery."

The physicality of analysis bears on an additional aspect of its bi-directional nature. Here I'm referring not to co-created *meaning* between the analytic couple, but rather to how analytic process fluctuates between two clinical orientation:1) the act of imaginatively (with its attendant physical effect) *inserting* the self into the other (typically but not exclusively by free association or interpretation); and 2) the act of imaginatively *receiving* (also with *its* attendant physical effect) the other's action into the self. Both clinical orientations entail the mind's innate inclination for progressive accessibility and integration. The underlying communication in the former reads: "I'd like you to reflect upon and internalize what I have to offer you" The receptive analyst in the second orientation opens up to being psychically entered, with the hope that sealed-off psychic experience will organically (without being consciously pried into or provoked) emerge and articulate (Freud's maxim [1923], "Where it was, there shall I become"). The analyst here conveys an open and safe curiosity with an uninhibited readiness to let the chips fall where they may, implicitly messaging the patient: "I am here to listen to, absorb, and consider what **you** say and do."

The rhythm, balance, and pace of this back-and-forth movement is idiosyncratic to each analytic pair. At bottom, it's established through unconscious sensorial "understanding" of the other's emotional readiness for one or the other action. Here our bodily sensitivity and our intuiting and reacting to body language is critical.

X

Personalizing Theory and Psychoanalytic History

> *The goal of the antiquarian is the dead past, the goal of the historian is the living present... History is the KNOW THY SELF of humanity – the self-consciousness of mankind.*
>
> – Jackson Turner (in Novey 1968).

History plays a critical role in our field and internalizing what came before us ensures its therapeutic value and cultural relevancy. For psychoanalysis is a collective phenomena, and its current meanings and methods have evolved from analytic generations and cultures of the past (Cushman 1995). We look forward by also looking back. Consequently, each generation, and all individual analytic therapists, must work out psychoanalytic theory all over again and for themselves, in a manner that's anchored in the past but original to the current time.

Comparing our analytic and intellectual ancestors' "voices" with our own today, may inform if we are saying something new and different that may be possible only within the historical and

cultural context of our times. If so, to what effect? Or speaking more generally, can we recognize ourselves in our forebears, and our forebears in us, and come out the better for it?

Thinking historically connects us with ourselves through time. Linking our sense of the past with our sense of the present provides understanding of how we've become the person we are today. Our identity, our sense of self, becomes more stable and secure. Connecting past and present also makes us better psychoanalytic thinkers and therapists. Internalizing the theorizing of our analytic elders, how they spoke about the mind and therapy, illuminates the human nature that grounds good analytic ideas and elevates our trust in their value.

Knowing the origination of our ideas, feeling connected to our roots, clarifies who we are as psychotherapists, how and why we think and act as we do. We become more comfortable with ourselves in our clinical work, more confident and personal, which makes it easier to theorize (and interpret) in plain, everyday language. Useful analytic theory is nothing more than "refined common sense" (Schafer 1982).

Tracking our psychoanalytic history also reveals our predecessor's mistakes and failures. More importantly, it uncovers how we may be repeating the same mistakes today. Realizing our

blind spots highlights the personal motivations and conflicts underlying our theoretical convictions. Are we unrealistically hoping theory will provide more self-repair than it possibly can? Are we exaggerating what it can do for our patients? Recognizing such idealizations lessens our disappointment in the limits of theory and enables its expression in more realistic, down-to-earth ways.

Specifying how we use our theories differently than our forebears also reveals the elasticity and subjectivity of psychoanalytic ideas.[9] Our understanding of their intent and meaning matures, increasing the flexibility and refinement of our analytic attitude and sensibility. As a result, our conviction in the practical utility of theory strengthens (see Grusky [1999, 2002]; Grusky and Goldberg [2012], on analytic conviction). On this point, Almond (2003) discusses the "holding function" of theory -- its capacity to meaningfully organize the labyrinth of analytic process.

We assimilate our predecessors' theorizing into our own voice and self-image; it becomes part of who we are, from an ancestor rather than a ghost (Loewald 1966/80). Integrating our differences creates subtle "paradigm shifts" in our conceptual thinking and clinical sense. Doing so expands and deepens our formulations (in the same way that our understanding of humanity

[9]The British analyst from the "early" days in London, Edward Glover, went as far as calling theory "an exercise in imagination" (cited in Reeder 2004).

expands and deepens from opening our minds to the "otherness" of alternative peoples, languages, and cultures). Our theories become more complex and comprehensive. The aesthetic rhythms and tones of their symbols and metaphors (in our writing, speaking, and teaching), now reflect and communicate the cultural reality of our times.[10]

Identity for Erik Erikson (1956) combines self-sameness (inner coherence) with interpersonal integration. Paul Ricoeur (1970) also connects individual selfhood with social unity. Tracing our theoretical history illuminates the self–other linkage these authors refer to. Discovering our unanimity with our ancestral past clarifies our distinctions as well, enabling our thinking to convey a singular style, one that's better aligned with our individuality.

Epilogue

> *There's a labyrinth of voices inside your head, a counterpoint of self-awareness and the remembered sayings of your guides and mentors, who don't always agree. Sometimes you wish you can go back and ask your teachers again to guide you...but you must simply find your way. They have given all the help they can; the only person who can*

[10]The cultural determinants of theory are critically important but this topic falls outside the scope of this paper. Suffice it to say for now that our theorizing progresses also by internalizing theories from contemporary analytic cultures and subcultures different from our own. Moreover, prejudicial cultural-conditioning of our theories has historically been used as a rationale to pathologize and exclude groups of people from psychoanalytic training and practice. For instance, the way homosexual men and women have historically been wrongly and hurtfully considered has deeply stained our profession.

solve the labyrinth of yourself is you.

– Jeremy Denk

Learning and growing as psychoanalytic therapists is hard work. We must imagine ourselves in the other and the other in ourselves, all the while keeping our personal boundaries clear, our feelings stable, and our thinking sharp. Clinical immersion teaches that freely and directly saying what's on our minds to patients in a psychoanalytically helpful way is extremely complicated and difficult to do. Ambiguity is a constant concern and positive results are usually quite subtle and hard to detect. This isn't to mention that the clinical mistakes and failures necessary for us to learn and develop as analysts can be extremely painful.

Analytic therapy is also sometimes frightening. Staying open to, and curious about, the "worst" in our patients and in ourselves, with no guarantee that doing so will turn out for the better, takes courage (Taylor 2007). Franz Alexander (1960) said that we can neither understand nor help our patients as much as we (or they) wish we could; our omnipotent wishes to cure are forever thwarted. No matter what theory we follow, loss, lack, and limitation – a tragic sensibility -- infuses our clinical sensibility and effort **(**Schafer 1982; Reiff 1959).

Everybody has a plan ...until they get punched in the nose.

– Mike Tyson

The actuality of psychic distress in analytic practice "hits" fiercely, profoundly, and permanently. In *Freud's Technique: More From Experience*" (2009), Lawrence Friedman contrasts the *theory* of "resistance" with its direct emotional *experience*. He elaborates the analyst's visceral "shock" of being entwined in conflict between her desires and those of the patient's. Friedman believes that negotiating this struggle mostly depends on the analyst's character. An academic grasp of theory helps only indirectly and generally.

The analyst's job entails emotionally containing and theoretically organizing the "punch in the nose" of resistance and other clinical difficulties. We try to balance our needs for recognition with respect for our patients' autonomy and freedom. Yet we often unwittingly flinch from harm's way, while leaving our patients in the lurch or trying to control their activity. Rather than shaping our theories around our patients' personalities and emotional needs, to varying degrees we unconsciously insist they identify with who we are, how we feel, and what we think. Jessica Benjamin (2004) writes that to "recognize that the object of our feelings, needs, actions, and thoughts is actually another subject, an equivalent center of being, is the real difficulty." Centering ourselves clinically without being clinically self-centered defines our challenge. This to me captures the "refined common sense" that our theories must embody

(Schafer 1982).

Psychoanalysis is but one of many progressive offspring of a self-reflective psychology arising in Western culture that dates back to the Platonic Socrates – "Do thy job and know thyself" – in which knowledge is obtained through systematic introspection into the self (Gedo and Pollock 1976). It began from one man's self-reflective solitude and will continue to evolve and prosper only by our doing the same today. Such lonely self-reliance falls heavily on our hunger for validation. But analytic wisdom and skill comes first and foremost from self-knowledge that's born from searching our internal lives. The above counsel that Jeremy Denk (2013) gives to his music students embodies fully our challenge as psychoanalysts. It's worth repeating as a conclusion to my discussion, as it encapsulates so well its inquiry into the radically personal nature of all psychoanalytic work: "There's a labyrinth of voices inside your head, a counterpoint of self-awareness and the remembered sayings of your guides and mentors, who don't always agree. Sometimes you wish you can go back and ask your teachers again to guide you...but you must simply find your way. They have given all the help they can; the only person who can solve the labyrinth of yourself is you."

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