Theoretical plurality and pluralism in psychoanalytic practice[1]

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The author begins by characterizing the present situation of psychoanalysis as one of increasing theoretical and practical diversity. The aim of this paper is to consider in depth the impact of theoretical plurality on clinical practice. After noting that the analyst has much more than evenly suspended attention in his[2] mind as he works with his patient in a session, the author reviews both older and more recent contributions on what the analyst has in his mind when working with a patient. He suggests that the subject has been addressed mainly from a single-person perspective. In this connection, and on the basis of clinical material, he attempts to show how, against the background of the 'implicit use of explicit theories', an ongoing process of decision-making that is co-determined by the patient's action and reaction takes place in the analyst's mind. In his analysis of a session, the author introduces the concepts of theoretical reason and practical reason, and contends that, whatever theories the analyst may have implicitly or explicitly in his mind, they ultimately yield to practical reasons. Pursuing the same line of thought, he describes validation in the clinical context as a single, wide-ranging, continuous process of social and linguistic co-construction of the intersubjective reality between patient and analyst. This process includes mutual aspects of observation and of communicative and pragmatic validation. In conclusion, he suggests that the figure of the craftsman is an appropriate description of the analyst in this conception of his work.

Keywords: psychoanalytic theory, psychoanalytic practice, pluralism, psychoanalyst's mind, psychoanalysis as craftmanship

Introduction: Plurality of theories and clinical practice

The last decade has been characterized by increasingly vigorous debate on theoretical and practical diversity in psychoanalysis. Two contributions by Wallerstein (1988, 1990) marked the official birth of a period of institutional discussion in international psychoanalysis. Wallerstein (1988, p. 5) recognized ''our increasing psychoanalytic diversity [...], a pluralism of theoretical perspectives, of linguistic and thought conventions, of distinctive regional, cultural, and language emphases''. In the light of this evidence, Wallerstein asks us ''what it is, in view of this increasing diversity, that still holds us together as common adherents of a shared psychoanalytic science and profession'' (ibid.). In his search for common ground, Wallerstein (1990, p. 7) suggests that this must be located ''in the clinical enterprise''. In his view, what we can have in common is a similar way of relating to our patients in the here and now of the interplay of transference and countertransfer-

[1]Translated by Philip Slotkin MA Cantab. MITI. The author would like to thank Dr Rodolfo Moguillansky for his valuable suggestions that improved the original manuscript.

[2]Translator's note: For convenience the masculine form is used throughout this translation for both sexes.

ence. At any rate, Wallerstein is here pleading for a change of focus from theory to practice – that is, to the privacy of therapeutic activity in the analyst's consulting room. And there is no doubt that the analyst's mind is an essential part of the intimacy of the clinical enterprise.

What we see in psychoanalysis is in fact not so much pluralism as mere plurality, or, worse still, theoretical fragmentation, since we lack a methodology for systematic comparison of the various theories and technical approaches. Ricardo Bernardi (2005) seems to share these fears when he wonders what comes after pluralism, and enquires into the conditions necessary for the diversity observed in the psychoanalytic field to become a factor of progress. Bernardi's research (2002, 2003) on how we psychoanalysts argue in our controversies leaves us with a pessimistic feeling about our capacity to meet on common ground. Yet David Tuckett considers that this crisis carries with it an opportunity for change:

> For too long, and too often, psychoanalysts have tended to conduct arguments in a manner more ideological than subject to reason. Arguments warranted by reference to authority, arguments derived from analogy or metaphor, the canonisation and 'Indexing' of texts, and a certain tendency towards isolationism from other disciplines relevant to our field, have been standard features of our discipline. [...] *it is time not only to review our methodology for assessing our truths, but also to develop approaches that will make it possible to be open to new ideas while also being able to evaluate their usefulness by reasoned argument. The alternative is the Tower of Babel.*
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> (Tuckett, 1994a, p. 865, my emphasis)

It therefore seems impossible to overcome the impasse without improving the rational basis of our arguments and, ultimately, without modifying the paradigm of the construction of theory in psychoanalysis (Jiménez, 2006; Thomä and Kächele, 2006).

In this contribution, however, rather than concentrating on this burning epistemological issue, I shall consider in depth the impact of the situation of theoretical plurality on clinical practice. Ultimately, after all, we clinicians must be capable of finding our bearings in the midst of an enormous diversity of theories of very different origins and levels of abstraction. This presents us with the challenge of operating with a number of theories simultaneously in our minds without losing coherence as we work with the patient.

Moreover, the situation has lately become even more complicated, as the growing permeability of the psychoanalytic community to neighbouring sciences and disciplines (the cognitive and affective neurosciences, research on the early mother–baby relationship, research on psychotherapeutic process and outcome) has added still more complexity to the psychoanalyst's clinical work. Besides metapsychological and theoretico-clinical publications, we are witnessing a growing number of applications of the theory of therapeutic change from fields outside but related to psychoanalysis proper (see, for instance, Beebe and Lachmann, 2002). In this way, a tension arises in the theory of therapeutic technique between traditional clinical knowledge and modern approaches based on empirical and experimental research, and this calls for a process of reflective integration with a view to maximizing synergy and coherence in our therapeutic activity.

Yet the enormous range and diversity of theories currently available to the analyst contrasts with the rarity of studies that seek to explore how the clinician's mind

works in a situation of pluralism. Quite probably, apart from possible causes in epistemology (Fonagy et al., 1999) and in the sociology of knowledge, the origins of the theoretical fragmentation may lie precisely in the lack of interest in exploring the complex psychological and knowledge-acquisition processes that unfold in the analyst's mind as one of the main sources of diversity and pluralism in psychoanalysis. Identification of the conditions in which pluralism operates thus becomes an urgent challenge, since, as Victoria Hamilton (1996, p. 24) points out, "although many psychoanalysts agree that pluralism is here to stay, it is not easy to spell out the connections between the ideology of pluralism and its application in clinical practice".

In the psychoanalytic debate, a frequent question is whether the different theories might have arisen partly from the analysis of different types of patients. This may be the case in part, but there are indications that pluralism goes much deeper, because the last few decades have brought confirmation that interpretations vary considerably even with material of one and the same patient (Bernardi, 1989; Pulver, 1987a, 1987b). If the question is posed in these terms, the exercise of pluralism of course becomes a difficult task. At any rate, the practical problem is how to work with the different theoretical models, given Strenger's view that:

> [p]luralism is *not* identical with relativism [...] The relativist says that the same proposition can be both true and false, depending on how you look at it. The pluralist shows that the standards of rightness associated with different versions can neither be reduced to each other nor meaningfully be taken to compete. The pluralist does not believe that the same proposition can be both true and false; he assumes that certain theories are incommensurable, i.e. not comparable with each other.[3]
>
> (Strenger, 1991, p. 160)

Jordán (2004) suggests that the capacity to make correlations and thereby to work with common sense with the patient in the session is facilitated if the analyst operates with more than one theoretical system in his mind. But as Gabbard (1990, p. 58) reminds us, "[f]or some clinicians, however, shifting from one clinical perspective to another, depending on the patient's needs, is too cumbersome and unwieldy". Wallerstein (1988), on the other hand, claims that it is possible to pay attention to the clinical phenomena described by each theoretical perspective without espousing the entire theoretical model. Many psychoanalysts do indeed consider that different patients with different psychopathological structures need different theoretical approaches. In this connection, Gabbard advocates pragmatism:

[3]Pluralism does not preclude realism, since the *a priori* condition of possibility for any theory in psychoanalysis and for any dialogue between psychoanalysts is that there shall be a reality that transcends the observer, even when it can be apprehended only fragmentarily and partially (Cavell, 1993; Strenger, 1991). On the other hand, the assumption of an intersubjective viewpoint does not on any account eliminate the concept of an objective world with which we are in contact and with respect to which we endeavour to be more or less objective. As Cavell (1998, p. 79) notes, "both a real, shared, external world and the concept of such a world are indispensable to propositional thought, and to the capacity to know one's own thoughts as thoughts, as a subjective perspective on the world". An idea such as this opens the door to pluralism – that is to say, to an intermediate path between a situation of total incommensurability between theories and a theoretical monism that could be upheld only from an authoritarian posture.

> Each of the[se] approaches to the theoretical pluralism of modern [psychoanalysis] is workable for some clinicians. Regardless of which approach is found more suitable, all clinicians should be wary of rigidly imposing theory onto clinical material. The patient must be allowed to lead the clinician into whatever theoretical realm is the best match for the clinical material. [...] Finding the theoretical framework that best fits a particular patient entails a great deal of exploratory trial and error [...]
>
> (Gabbard, 1990, p. 58)

The analysing mind: Something more than evenly suspended attention[4]

It is hardly necessary to say that if it is necessary to find common ground in clinical practice, the study of what the analyst 'has in his mind' is bound to encounter problems from the beginning, for the simple reason that what the analyst may *really* have in his mind during analysis is not obvious on an absolute level. All that is really clear is what he ought to have in his mind – or rather, what he ought not to have in it. This was determined by Freud himself in his recommendations on technique (Freud, 1912). Freud's advice can ultimately be subsumed in a single precept, inherent in the rule of 'evenly suspended attention', whereby the analyst is counselled to behave like a remote surgeon who puts aside all his feelings, or a mirror that reflects only what is shown to it.

Yet Freud's preceptive intent met with an important obstacle – namely, the inevitable existence of blind spots in the analyst's psychoanalytic perception. Freud had no doubt that observance of the psychoanalytic method was constantly jeopardized by various resistances arising within the analyst himself. It was but a vain hope that Ferenczi (1928) was expressing when he claimed that the training analysis – the "psycho-analytic purification" (Freud, 1912, p. 116) – would help to eliminate the blind spots and, with them, the theoretical and technical divergences in psychoanalysis.

However, Ferenczi himself stressed the immense complexity of the mental work expected of the analyst: allowing the patient's free associations to act on him; giving free rein to his phantasy to enable him to elaborate the material supplied by the patient's associations; comparing in the here and now newly emerging links with previous results of analysis; and exercising unremitting vigilance over, and maintaining a critical eye on, his own subjectivity. In the view of Ferenczi (1928, p. 96), the analyst's mind "swings continuously between empathy, self-observation and making judgements".

We do now know, from his letter of 4 January 1928 to Ferenczi, that Freud was aware of the limitations of his recommendations. With regard to the title of Ferenczi's contribution on the *elasticity* of technique, Freud writes:

> For my recommendations on technique which I gave back then were essentially negative. I considered the most important thing to emphasize what one should not do, to demonstrate the temptations that work against analysis. Almost everything that is positive that one should do I left to 'tact,' which has been introduced by you. But what I achieved in so doing was that the obedient ones didn't take notice of the elasticity of these dissuasions and

[4]I use the concept of the 'analysing mind' to denote the mind of the analyst working with his patient in the session. The idea is that the analyst's analytic competence extends far beyond the 'analysed mind'.

> subjected themselves to them as if they were taboos. That had to be revised at some time, without, of course, revoking the obligations.
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> (Falzeder and Brabant, 2000, p. 332)

Of course, we analysts are to this day debating the nature of the ''obligations'' that are held to define what is specifically psychoanalytic, but have not arrived at clear or definitive conclusions.

Be that as it may, a growing consensus has arisen in the last few years to the effect that there is much more to the analyst–patient relationship than the mere interplay of transference and countertransference. According to a broad conception of the psychoanalytic relationship, the ''real characteristics of the participants and a highly primitive object relationship'' (Infante, 1968, p. 767, translated) are the support and framework of the analytic process. Various authors (Arlow and Brenner, 1988; Bernardi, 1989; Pulver, 1987a, 1987b) have demonstrated the effect of the theories the analyst has in his mind on selective listening to the material. Meyer (1988) points out that the analyst's personal equation is also manifested in cognitive styles that condition his attitude and the way he perceives and thinks of the patient. Stein (1991, p. 326) suggests that the ''analyst's emotional reactions in the analysis depend on the analyst's theoretical convictions of what does and does not constitute good analysis''. On the other hand, it is hard to overestimate the preceptive functions of the visions of man and the world implicit in the various theories, whether personal or those of schools of thought.

In the last few years, exploration of the mental processes of the analyst as he works with his patient has been boosted by the activity of the European Psychoanalytical Federation's Working Party on Theoretical Issues (EPF-WPTI), which opted to consider first the issue of the role and significance of implicit (private, preconscious) theories in clinical practice (Canestri et al., 2006; Silvan, 2005). This research programme takes as its starting point the pioneering view expressed by Joseph Sandler in 1983:

> With increasing clinical experience the analyst, as he grows more competent, will preconsciously (descriptively speaking, unconsciously) construct a whole variety of theoretical segments which relate directly to his clinical work. They are the products of unconscious thinking, are very much *partial theories, models or schemata*, which have the quality of being available in reserve, so to speak, to be called upon whenever necessary. That they may contradict one another is no problem. They coexist happily as long as they are unconscious.
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> (Sandler, 1983, p. 38, my emphasis)

In the construction of the 'map of private (implicit, preconscious) theories in clinical practice' (Canestri et al., 2006) the WPTI offers the psychoanalytic community a systematic qualitative research design based on the study of (a) clinical reports of analytic work, (b) the clinical experience of the group members, and (c) each analyst's negotiation of the public theory that he espouses in a wide range of contexts. On the basis of these experiences, the authors have identified six categories, or vectors, that seem relevant to how concepts are used in the practice of psychoanalysis. Applying a heuristic model, they explore the psychic space of the analyst's theory, ordering it in accordance with differing theoretical and motivational elements and knowledge structures and with its topographical classification. The vectors are not independent of each other, and various elements classified within one vector may also be included in another. In terms of the model, these vectors interact

dynamically, determining the formation of clinical judgements and the analyst's therapeutic interventions in accordance with the weight or value assigned to them.[5]

Exploration of the 'implicit use of explicit theories' (Canestri, 2006) admittedly casts light on the concrete conditions brought about by pluralism in the analyst's mind. However, in my view, one aspect is insufficiently considered in this approach. This concerns the way in which the various vectors or categories described by the WPTI interact in the analyst's mind and in the analytic situation. It seems to me, as I hope to illustrate later with clinical material, that what could be called the 'movement' or dynamic of 'partial theories, models or schemata' (Sandler) is co-determined by the patient in his interaction with the analyst. The problem of an interpersonal and intersubjective heuristic arises here, because what is involved is the role we assign to the link (or interaction) between two minds working together. By this I am suggesting that in the analyst's mind there comes into being an ongoing progress of decision-making which, against the background of the 'implicit use of explicit theories',[6] is constantly influenced by the patient's action and reaction. The processes of validation – or invalidation – of the analyst's interventions take place in the course of this interaction.

The recent work in progress of the EPF's Working Party on Theoretical Issues is connected with earlier developments that date back to Ferenczi himself and can be included in the current debate. In addition to the study by Ramzy (1974) on analytic inference, some authors, influenced by the 'emergence of cognitive psychology' (Holt, 1964), have made important contributions to the investigation and description of the analyst's mental phenomena during a session (Bowlby, 1969; Greenson, 1960; Heimann, 1977; Peterfreund, 1975). What all these authors have in common is their dissatisfaction with metapsychology as an appropriate theory for describing and understanding how the analyst's mind works in sessions with the patient. In the view of Holt (1964, p. 650), the analyst's cognitive processes include a wide range of phenomena: ''perceiving, judging, forming concepts, learning (especially that of a meaningful, verbal kind), imagining, fantasying, imaging, creating, and solving problems''.

In his study of the analyst's processes of 'emotional knowing' (that is, the process of empathic understanding), Greenson (1960) suggests that in his daily work with the patient – concretely, during breaks or in the explanation of disruptions of empathy – the analyst constructs a working model that combines different aspects

[5]The six vectors, or categories, are (Canestri et al., 2006): (1) the topographical vector, which contains the psychic level on which theoretical thought takes place (non-public conscious, preconscious, or unconscious); (2) the conceptual vector, which includes ideological formations or ones containing a vision of the world (e.g. tragic or romantic); (3) the 'action' vector, which includes the role ascribed to evenly suspended attention in listening, the way in which interpretations are formulated verbally, and the way the analyst interacts practically with the patient; (4) the 'object relations of knowledge' vector, which includes the affiliations and loyalties resulting from the psychoanalytic training system; (5) the 'coherence versus contradiction' vector, which includes the way in which contradictions are handled theoretically (elasticity and tolerance of contradictions); (6) the developmental vector, which includes evaluation of the preferred type of material (verbal or non-verbal) or of a given phase of development.

[6]'Implicit *use*' indicates a process of decision-making determined by practical reasons that assess the use-related value, or *utility*, of explicit theories at a given moment. The guiding question in this case is not *why* but *for what purpose.*

and characteristics, both physical and psychic, of the patient. In the course of analytic work the analyst listens "through this model" (ibid., p. 421):

> The conception of a working model of the patient implies a special kind of internal object representative. It is an internal representation which is not merged with the self and yet is not alien to the self. By cathecting the working model as a supplement to the external patient one approaches the identificatory processes.
>
> (Greenson, 1960, p. 423)

Empathic listening through the working model is a function of the analyst's experiential self. According to Bowlby (1969, p. 82), the "[...] models described here [...] are [...] none other than the 'internal worlds' of traditional psychoanalytic theory seen in a new perspective". The stored programs and data that make up the various operational models represent specific selections of the total data available over time (Peterfreund, 1975, p. 61). The working model thus becomes the result of all the theoretical information and practical experience acquired by the analyst over time. The operational models are mini-theories in action and should be seen as partial theories in their concrete reference to the here and now.

Heimann (1977, p. 317) insists that the analyst's understanding is not confined to introjective identification with the patient's internal objects. We understand a patient beyond such processes, "by forming a mental image of him, by grasping with our imaginative perception his problems, conflicts, wishes, anxieties, defenses, moods, etc.". The formation of this mental image is a *creative* process on the analyst's part. The working model is thus in a state of constant evolution, gradually adjusting and drawing closer to the patient's reality.

Working models provide the analyst with strategic guides to therapy – that is, to the role of the analyst as a participating observer, the particular handling of the analytic dialogue, the discovery of unconscious meanings, and the formulation and articulation of verbal communication and interpretation; in sum, to all the activities that define the analytic method. The analyst also has a repertoire of working models applicable to his manner of feeling, reacting, and working with different categories of patients (Peterfreund, 1975).

From this point of view, evenly suspended attention opens the analyst's mind, enabling him to listen to the signals of different types within the verbal and nonverbal material offered by the patient. These signals activate working models – a few of which are conscious in nature, but the majority preconscious – of different kinds and levels of abstraction, which the analyst, as the outcome of a continuous process of introspection and by making use of his capacity for creative synthesis, will consciously compose into interventions appropriate to the specific therapeutic needs of each patient. Acting as an intermediate phase, the model in this way connects emotional experience and theory in the analyst's mind. The model concept seeks to throw light on the course of, and interaction between, the experiential objects of evenly suspended attention and theoretical formulations.

An analytic session

Mrs C is just starting her sixth year of analysis at a frequency of four sessions a week; she came for a consultation on reaching the age of 40 because she could no longer tolerate the depressive pain that had been afflicting her for many years.

She had been involved in the resistance to the Pinochet dictatorship, during which she had been exposed to dangerous situations and suffered traumatic losses of companions of both sexes in the struggle. Fifteen years earlier, her partner had been killed, and this had plunged her into profound mourning. Mrs C had then consulted a psychotherapist, but the relationship had ended abruptly after a few weeks following a session in which he made sexual advances to her, taking advantage of her helplessness and need for protection. This experience exacerbated her sense of emptiness and gave rise to a feeling of resentment towards therapists, so that she postponed a further consultation until her symptoms became difficult to tolerate. Ten years previously, she had married. The relationship with P had "helped me to endure the pain".

The first years of her therapy, characterized by a climate of sensitivity and patience, were occupied by the analysis of her mourning, guilt feelings, and idealization of her dead and 'disappeared' companions. The result was the gradual appearance of greater vitality, accompanied by aggression and rivalry. Mrs C's modesty and gentleness were interrupted a few times by episodes of intense rage directed at myself, in which she contemplated the idea of abandoning the treatment. As a rule, these were triggered by situations in which she could no longer keep at bay the knowledge that I was a separate person, with independent opinions of my own: her intense rage arose out of the painful experience of rejection and humiliation. The idealization of the analyst concealed feelings of resentment towards men, and, in particular, towards her father. As the idealization diminished, there developed a threatening erotic transference which, as the expression of a phantasy of erotic and narcissistic fusion, proved to be a defence against the consciousness of her wish to be a man and her profound sense of inferiority at being a woman.[7]

The symptomatic and structural changes taking place in Mrs C were obvious and in line with Freud's hypothesis of the bond [*Junktim*] between self-knowledge and cure, all within the framework of a vigorous analytic process.

Just before the session transcribed here, the last of the week, Mrs C spent a week abroad for work reasons. The session takes place a few days prior to a break for a week and a half on my account. So it is a session between two breaks, hers involving four and mine six missed sessions. The report I am about to present was written up immediately after the session, based on memory. The text in square brackets gives information on what I felt and thought during the interaction with the patient.

Patient: Last night I had a dream: I was with P [her husband] and there were three other men, dressed in black. One of them lifted up his shirt and showed me a patch of skin that was red with eczema and weeping. This had quite an effect on me. Another man said: "Finally I meet someone with the same thing as myself". He lifted his trouser leg up to the knee and also showed an area of inflamed skin that was weeping; liquid was oozing out of it. Something happened with the other man, but I can't remember. I did not like this at all, and told P we should leave.

[7]Without going into detail, I am here referring to the concept of penis envy, or the wish to have a penis. This has no implications with regard to Mrs C's sexual orientation. In fact, her sense of inferiority at being a woman affected her gender role identity, so that her view of men was permeated with resentment and rivalry. This theme appears in the session reproduced here.

We crossed a desolate, stony piece of land, like those panoramas you see in science fiction films after a nuclear catastrophe, and then we met up with a group, this time of women, also all dressed in black. We had to cross a place like a dammed-up lake or ravine, but this was very dangerous, because every so often the water came and flooded everything. We thought we would have a go, but one of the women, M, an old acquaintance of mine, told me that it was extremely dangerous, and that she had decided not to do it, because one had only a few minutes to find somewhere to cross without the water coming. P and I began to cross, but in a funny direction; instead of going straight across, we set off the other way, lengthwise. It was a place full of caves – very odd. Eventually some narrow stone staircases appeared, which you could go up to reach the other shore. I said: ''Let's save ourselves by going this way'', and we began to climb the stairs. But P did something – made some movement – that suddenly pushed me up together with the steps and left me hanging, on the verge of plunging into an enormously deep abyss. I panicked; I could feel the wind in my face, and did not want to die. I told P: ''Please let me down, as I could fall and die at any moment''.

I woke up in terror, like at five in the morning, and had trouble falling asleep again; I was afraid of continuing the same dream.

[Several long minutes passed after she brought the dream. The dream itself had been told slowly, with dramatic intensity and very cautiously, as if she were choosing every word. Her account grabbed my attention, aroused my curiosity, and immediately set my own theories-cum-phantasies in motion. Fleeting ideas passed back and forth in my mind: today, I thought, was Thursday, before the weekend break and a few days before a six-session break attributable to me. Might P stand for me, JP? Might this movement that leaves her on the verge of the abyss have anything to do with my absence? Have these men showing their wounds been castrated? Men and women in black and a desolate landscape put me in mind of prolonged mourning, Mrs C's chronic depression, the traversal of the analysis. Men and women separate from each other, a couple trying to traverse a landscape already devastated by a nuclear catastrophe – what kind of primitive tragedy is being staged in the dream? An oedipal tragedy, or traumatic losses? After all, her account had taken up about a quarter of an hour, and I felt that there was more in it that had not been said than had actually been expressed. It seemed to me that what was most important were the silences. For this reason I opted for a circumspect, expectant attitude. Of course, I had many things that I could use as a basis for breaking the long silence that followed her account. For example, I could ask her for associations, or enquire what might have caused M to decide not to cross to the opposite shore. But I waited for a few more long minutes. I went on thinking and observing how she settled down on the couch, wrapped in the blanket. What a difference compared with the beginning of the analysis, five years ago, when she hardly looked at me on coming in and going out, and always had a gloomy, scared expression on her face! How hard it had been for her to decide to lie down on the couch. It was only after a couple of months that she had dared to abandon the face-to-face setting. Now, on the other hand, she would come in with a broad smile, look me squarely in the face, and, after taking the blanket, wrap herself up in it and lie down in relaxed fashion on the couch.]

[She interrupts my train of thought.]

P: The dream must have something to do with my sexuality. Er ... It's hard for me to talk about this. Er ... Even though I have been in analysis for years, I feel ashamed and frightened. I don't know – why is it so difficult for me? Why can't I speak more freely, and simply tell you things ...?

[A fresh silence ensues.]

Analyst: Tell me things which you already know about your dream, but which you keep quiet about, which you reserve for the silences, the pauses, and put them into your slow, cautious telling. For example, I think you know why M appears in the dream; you must know what kind of difficulties made M decide not to cross the dammed-up lake.

P: Er ... M is gay, and men cause her enormous panic. [A silence.] Yes, of course, this fear of talking about my sexual phantasies. I've always been used to casting them aside as soon as they appear, and it terrifies me to get in touch with them.

A: Panic ... about getting turned on? That's something very dangerous. Crossing this ravine, going into the caves – sex. It seems you have to do it, but without getting turned on, without pleasure, and without enjoyment. Getting turned on and enjoying yourself bring you to the verge of the abyss. The dam might burst and flood you all of a sudden with dangerous pleasure.

P: Er ... All right then. [Resolutely.] Yesterday there was something I didn't mention. At X, I was given a fantastic room, with a spectacular view. I took a few books along with me, and the music I prefer, and I enjoyed lying down reading and listening to music. It was a huge pleasure. For three nights I had intense erotic dreams about the Mexican delegate, the *enfant terrible* of the seminar, the one you said yesterday had been the star. That man … Er ...

A: Lying down, settling down, starting to feel good here and to feel pleasure – phantasies come up, talking to me about them, here ... it's all very dangerous.

P: Every day lately I've been thinking I should go far away and meet an attractive, intelligent fellow so that I can have sexual phantasies and feel secure, without a catastrophe happening. But, er ... I realize that the Mexican is a substitute for you. The whole thing is with you. It makes me feel very ashamed and, what is more, afraid. As if I were a little girl and you were going to punish me severely for these thoughts.

[I wonder if not only the Mexican but also P in the dream is a substitute for JP – that is, for me. I feel wrapped up in the erotic idealization. I let myself be moved by her and think of the boundaries between analysis and life. Working with Mrs C, I often have the impression that she experiences me directly as a primary experience – as if it was not a matter of transferences, but of very early experiences: there is an element of fusion and lack of differentiation in the relationship with her. The thought crosses my mind: how far does transference interpretation go? If I interpret that I am identified with her husband, saying something like "The people crossing the dammed-up lake are you and I, as a couple, and so I am the one who turns you on", would I not be committing an iatrogenic act? The catastrophe – going to bed with her analyst? I realize that Mrs C is indeed right to perceive the danger; what must it have been like with the first therapist? I must tread a narrow path

between accepting the idea of occupying her husband's place and not crossing the line of seduction. I think of the incest taboo. How am I to do this? I decide on a cautious approach to the transference-related erotic phantasies.]

A: Be that as it may, it seems obvious that, yesterday and today, you feel more secure on the couch, because you are gradually bringing me closer to your sexual phantasies. Of course, the problem is that, the more you can settle down here, wrap yourself up in the blanket ...

[She interrupts me.]

P: Yes, that's right, ideas I dare not mention come up in me.

A: You don't only have to travel abroad; there also has to be a step, a situation here, a bridge, between your trip and my break next week. There, there's no danger. You can talk today, Thursday, and then there will be three days' break; another few days, and you won't see me for six sessions.

P: Yes, that must be what makes me feel secure here ...

A: That there won't be any catastrophe. At any rate, there are so many things in the dream, so much information that we can't manage to analyse today – there are only a few more minutes to the end of the session. You have taken your time, you've been very slow and cautious. It's as if you were showing and not showing at the same time.

[I stop there, although I would have liked to continue, saying something more or less along the lines of: what is it that's being hidden? The skin with eczema, oozing pus, inflamed – a painful, agonizing sexual excitement? Who are we talking about? Mutilated men inside yourself? Something of yours that you see in men? What is this business about homosexuality? On the other hand, you have always presented P as uninterested in sex and unattractive to you. Yet in the dream, P is evidently capable, with just one movement, of turning you on, making you panic, and putting the fear of death into you. And another thing: won't this dream have the effect that you'll go underground until there's another opportunity here in the analysis – another situation that will make you feel secure?]

[Just as I am having this last thought, she surprises me with the following words.]

P: Hopefully the subject will not go underground – because I realize it's crucial and important. A great deal depends on understanding my sexuality. I'm different; a lot has changed. I'm not terrified any more by the things that used to frighten me. I feel more secure in my life and work, and with myself. On this trip, some very important things happened to me inside, even though I haven't fully understood them yet. Evidently I feel that I can do things in another way – that I can live differently, with more enjoyment, and have more pleasure in life.

Theoretical reasons and practical reasons

I wanted to present this particular session of an eight-year analysis because I believe it illustrates the thesis that the theoretical reasons the analyst may have in his mind, whether consciously or preconsciously, ultimately yield to practical reasons. By a practical reason, I mean the capacity to use reflection to answer the question of

what one must do at a given time.[8] In our case, the question is: what consideration made me wait rather than making an interpretation, even though I had so many possible interpretations in my mind? Looking at events after they have happened, one can ask why they occurred. However, if we put ourselves in the situation in which they are happening – that is, in my place at the time when Mrs C is telling her dream and settling down on the couch in silence – it will be understood that my problem there was not one of explanation, but of prediction; that is to say, of determining what would happen in the future, how Mrs C would react if I were to interpret in this way or that. Practical reasons thus seek, on the basis of a set of alternatives, none of which has yet come about, to answer the question as to which alternative is the best – that is, as to what is to be done. So it is not a matter of questions of fact and their explanation, but of issues of value, of what it is desirable to do. In the analyst's mind during the session, there is a constant movement between, on the one hand, theoretical reasons which, in the form of partial mini-theories (conjectures), will make it possible to understand and explain the interaction of the moment in terms of the knowledge acquired during the course of the process, and, on the other hand, practical reasons, which guide the taking of decisions on what to say and when and how to interpret. If material from subsequent sessions were to hand, we would surely find answers to many of the questions I silently put to myself during and after the telling of the dream. However, that is not a situation that corresponds to the reality of the moment, because it is not a matter of finding *ex post facto* explanations (theoretical reasons), but of venturing predictive hypotheses about something that has not yet occurred. In practical reasoning, the agent seeks to evaluate and weigh up his reasons for acting – to ponder about what argues for and against the alternative courses of action open to him.[9] Furthermore, this decision is finally taken in the first person – that is, from a subjective point of view, in terms of the particular situation in which one finds oneself at that moment. The decision thus carries with it the full singularity of an encounter with another in the *here and now*. This is an ideographic, creative, and ineffable moment, when the analyst takes a risk which, for reasons of principle, can never be wholly covered by theory; it is so to speak a moment 'devoid' of theory. At this point, we must perhaps espouse the epistemological doctrine of *probabilism*, according to which only approximate knowledge is possible, and any claim to absolutely certain and sure knowledge is precluded on principle (see Ferrater Mora, 1969).

However, that is not the end of the problem. The decision to intervene in the way I did – that is, the decision *not* to intervene – remained in abeyance, pending Mrs C's reply. It was she who validated my action by saying, ''The dream has to do with my sexuality'' and by confiding in me about her fear and shame of confessing her erotic wishes and phantasies concerning myself. By her intervention, she 'gave me permission' to select some of the many interpretations that I had thought

[8]The distinction between theoretical and practical reasons is an ancient philosophical problem that can be traced back to Aristotle himself. The *νουσ θεωρητικοσ* differs from the *νουσ πρακτικοσ* in the character of its end. Practical reason is stimulated by the object of the appetite. The Scholastics followed the tradition by drawing a distinction between speculative reason and operational reason; this distinction was also taken up by Kant, who emphasizes that the two reasons – theoretical and practical – are not two distinct types of reason, but one and the same reason, which differs in its application (see Ferrater Mora, 1969; Wallace, 2003).

[9]If this involves the *use* of theories, the question now shifts towards the *utility* or *use-related value* of these theories.

up in silence. In analytic work, in other words, practical reasons are validated by the patient's response.

So what was the consideration that made me wait, rather than interpreting, even though I had so many possible interpretations in my mind? The answer does not seem difficult: the patient's way of bringing the initial dream suggested to me that, through the telling, an emotional experience whose development I had to respect was unfolding, even though I was not clear about what precisely was being staged at that moment. Very probably, I was aware, in some part of my mind, of Mrs C's sensitivity and the traumatic situation with the previous therapist, so that I perhaps thought that it was good for her to 'use' me in her internal world as a sexual object in a context of security [... I feel wrapped up in the erotic idealization. I let myself be moved by her and think of the boundaries between analysis and life ...]. What is certain is that my posture of silence and non-intervention seems to have made it possible for Mrs C herself to have been the one who explained the meaning of this emotional experience – for her to have interpreted her own conduct. What unfolded was her own sexuality – and, furthermore, it did so in the register of her transference on to me. The countertransference affect that guided me in my silent waiting was one of positively toned calm expectation: I felt good when I saw that Mrs C was able to be with me without the anxiety she had shown at the beginning. [What a difference compared with the beginning of the analysis, five years ago, when she hardly looked at me on coming in and going out, and always had a gloomy, scared expression on her face! ... Now, on the other hand, she would come in with a broad smile, look me squarely in the face, and, after taking the blanket, wrap herself up in it and lie down in relaxed fashion on the couch.] In addition, the primacy I attribute to emotional experience in the analytic situation presumably arises also out of my knowledge about research on process and outcome in psychotherapy and psychoanalysis, which show that the patient's experience of the analyst is of crucial importance as a prognostic element and curative factor.

In this connection, I am aware that my approach here also presupposes the theory that the analyst must, in the analytic situation, create the conditions of security necessary for the unfolding of a new emotional experience in which ancient fixations on to bad objects can be overcome, while at the same time encouraging new, more positive identifications. My conception of the analytic process is thus a relational one. The creation of such conditions in this case took priority over interpretive work, at least as regards interpretation of the dream contents.

Validation in the clinical context

Validation in the clinical context – that is, within the session with the patient – is a continuous and inescapable process. As Tuckett (1994b, p. 1162) writes, it "is part and parcel of accepted analytic technique that we seek to amend our understanding and interpretation according to a constant subjective monitoring of the 'truth' of what we think is happening". Tuckett distinguishes two levels in the overall validation process: *micro-validation* within the session, and *macro-validation*, which takes place in the absence of the patient. Rubovits-Seitz, too, presupposes the existence of these two levels in his statement that:

> Interpretive validation during the treatment of patients depends on the error-detecting and error-correcting strategies of checking, revising, comparing, and selection of alternative constructions. [However, he adds] [m]ore definitive [*ex post facto*], post-analytic validation requires a record of the analytic process, which the analyst can study systematically and retrospectively in as much detail as necessary.
>
> (Rubovits-Seitz, 1992, p. 162)

Although I am concerned here to explore in more detail the process of micro-validation – that is, the constant activity of monitoring, together with the patient, what we believe is happening during the session – I must again point out that my focus in this contribution is not so much on the validation of interpretations as on exploration of the working of the analyst's mind in a situation of theoretical pluralism.

At any rate, with regard to the scope of micro-validation, I agree with the recent recommendation of Kächele, Schachter, and Thomä (in press) that we should put an end to the interminable debate about the validity of individual interventions and interpretations, considering only the context of one particular session, given that all these interventions and interpretations are part of a wider game. As Freud's chess metaphor implies, the value of an individual move can be determined only on the basis of the general state of the game. Hence the value of the interventions in a given session stems from their functional utility at a particular moment in the overall process.[10] From this point of view, the micro-validation procedure corresponds to the application of practical rules, or rules of the art – that is to say, the set of precepts to be followed by the analyst in order for the operations carried out to be 'correct' or, in other words, for his interventions to lead directly to the desired end. Micro-evaluation thus belongs to the sphere of practical implementation of the psychoanalytic method.

The subject of valid knowledge is related to the philosophical issue of truth. There are three classical criteria of truth: correspondence, coherence, and pragmatic utility. In this context, attempts have been made to apply such criteria to the matter of validation of the psychoanalytic method (Hanly, 1990; Strenger, 1991). For a long time, the idea prevailed that the object of psychoanalysis was the search for the truth of the unconscious. The last few decades, however, have witnessed "a redefinition of the object of [psychoanalytic] study; that is, the particular intersubjective figure constituted by the analyst–patient relationship" (Canestri, 1994, p. 1079). In this last sense, it is no longer possible to continue to separate investigation of the unconscious from consideration of the investigative intentions of patient and analyst, and much more is clearly involved than contemplation of the conjectured truth of the unconscious. To paraphrase Sandler and Dreher (1996), we cannot continue to ignore 'what analysts and patients want'.

From the point of view of the validation of psychoanalytic work during the session, the three classical criteria of truth can be regarded as abstractions of a single,

[10]With regard to extra-clinical validation by an empirical methodology – as consistently pursued by these authors over a period of 40 years – Thomä and Kächele seem to incline towards the epistemological doctrine of statistical probabilism. Multi-dimensional single-case studies using empirical methodology reveal *tendencies* or statistical regularities in the patient's response, which, during the course of the treatment, lose stability and are replaced by others (Kächele et al., 2006). Whereas the study of an individual session can throw light on aspects of the preferred techniques applied by the analyst or the explicit use of his implicit theories, it cannot provide a definitive answer to certain questions that are crucial to psychoanalysis, such as, for example, the issue of curative factors. This would require systematic research on aggregated single-case studies.

broad validation process that includes *observation*, *conversation*, and *interaction* (Kvale, 1995). For it to be applicable to psychoanalytic reality, the classical idea of knowledge as a reflection of reality (the reality of the unconscious) must be replaced by a conception in which knowledge is a social and linguistic co-construction of the intersubjective reality between patient and analyst. In the analytic situation, analyst and patient are constantly interpreting and negotiating the meaning of the relationship between them, and this becomes the material of their communication with each other. Conversation becomes the ultimate context within which knowing must be understood (Rorty, 2000). Truth is constituted by way of dialogue, and valid knowledge emerges as the result of alternative, conflicting interpretations and possibilities of action, which are discussed, negotiated, and discerned in accordance with the rules of the psychoanalytic method. This certainly has nothing to do with relativism or the notion that 'anything goes'. The *a priori* condition of the dialogue is the belief in (and, in a strong sense, the affirmation of) a truth that transcends us (Cavell, 1998; Strenger, 1991).

In the clinical context, what matters is the relationship between meanings and acts, between interpretation and action. If the dichotomy between facts and values is abandoned, the dimensions of aesthetics and ethics are added to that of truth. In the case of a social construction, the beauty and use-related value of the constructed knowledge move into the foreground. The result is a shift from a psychoanalytic model based on archaeology, whose object is the discovery of a concealed truth, to an *architectural model*, in which the main concern is the construction of a new house (Adolf Meyer, personal communication). The emphasis is then placed on pragmatic testing through action. The issue of the value of knowledge no longer belongs to a field separate from 'scientific' knowledge, but is intrinsically linked to the creation and application of that knowledge.

Hence validation in the analytic session is an ongoing process of checking of hypotheses and conjectures, of questioning of these, and of comparison with the theories and models which the analyst has to hand at that moment. In this process, the coherence of the discourse itself becomes a criterion of validation. However, validation also involves checking the relevant knowledge with the patient. Through dialogue, analyst and patient arrive at a consensus, or take note of their differences, on what has been observed, on what will, for them, be deemed 'clinical data', and on its meaning. (In the session with Mrs C, analyst and patient arrived at a consensus on the clinical fact of 'settling down on the couch' and its erotic meaning). Of course, the aspect of power is always present in this. In order for communication in the analytic situation to be genuine, there must be 'democratic' conditions that reduce the area of asymmetry to what is strictly necessary. (At the end of the session with Mrs C, we observe a phenomenon of parallelism – that is, of symmetrization – between the analyst's and the patient's thought, which amounts to communicative validation: while the analyst is thinking, "*Won't this dream have the effect that you'll go underground until there's another opportunity here in the analysis – another situation that will make you feel secure?*", the patient interrupts him, saying, "*Hopefully the subject will not go underground*").

However, the achievement of consensual knowledge on observations and their meanings is not all there is to validation in the clinical context. The pragmatic validation of interpretations extends beyond communicative validation. Interest – which guides the practical reasons for helping patients to achieve the desired

change – is intrinsic to the therapeutic enterprise. For Freud, one of the distinguishing features of psychoanalysis was, precisely, that research and treatment went hand in hand with each other. Whereas communicative validation includes an aesthetic aspect, pragmatic validation implies the ethical dimension.

Two types of pragmatic validation must be distinguished. In the first type, the validation of a statement is based on the actions that accompany that statement. This applies particularly to the analyst's consistency in his therapeutic activity. The analyst's conduct is not ethical when his actions belie his words. Mrs C's treatment would not have been possible had she not convinced herself that her erotic phantasies and wishes would remain precisely in the sphere of the thinkable and communicable, without attaining the level of carnal facts; she 'validated' her analyst as someone reliable. The second form of pragmatic validation, which is more relevant to our discussion, concerns the question of whether the interpretations that the analyst negotiates with his patient do indeed finally succeed in giving rise to changes in the patient's internal world and behaviour. For Freud, communicative validation did not suffice; for him, a patient's 'yes' or 'no' in response to the therapist's intervention never constituted sufficient confirmation or invalidation. He recommended more indirect forms of validation, through the observation of changes in the patient's behaviour subsequent to an interpretation, such as changes in associations or dreams, the appearance of memories, or symptomatic changes. Spence (1982) stresses the pragmatic effects of interpretations: narrative truth is constructed in the therapeutic encounter, carries with it the conviction of a 'good history', and must be judged both for its aesthetic value and for the curative effect of its rhetorical force. Ricoeur (1977, p. 868), for his part, holds that "therapeutic success [...] constitutes [...] an autonomous criterion of validation". What Mrs C says at the end of the session transcribed here – "I'm different, a lot has changed. I'm not terrified any more by the things that used to frighten me. I feel more secure in my life and work, and with myself" – can be deemed sufficient pragmatic micro-validation. With regard to post-treatment pragmatic validation, I reproduce below my exchange of letters with Mrs C concerning my request for her consent to the publication of a session from her treatment, eight years after the end of her analysis:

> Dear Mrs C, I enclose the paper I mentioned on the telephone. You will see that for the purpose of illustration I have included material that you will certainly recognize. I have tried to disguise the people featuring in it as far as possible. It is not easy for me to ask you to consent to the publication of this material. I understand that there is an intimacy that we must respect. However, there are also scientific interests: one of the most serious problems for the progress of psychoanalysis is the inhibition that we psychoanalysts have about showing what we do and what really happens in the consulting room. I hope that you will understand my motivation. Any suggestion about the material will be welcome.

> Dear Doctor, Of course I recognized the dream (that one, and I remembered others, which were also very significant); I also recognized that stage of the analysis, when I finally began to emerge from pain, which was just pain, pure pain. I cannot deny that the unveiling of your thoughts, emotions, and feelings through the account and analysis of the session is also important for me. I do of course feel that my privacy is protected, and in reading your paper I feel close not only to your reflections but also to the treatment, which has resulted in such an important change in the way I have lived my life since.

The analyst as craftsman and artist

As we have seen, in the theory of technique there has been a tendency to restrict the analyst's mental processes to description of the ideal conditions of observance of the rule of evenly suspended attention. This position, first formulated by Freud (1912) in his recommendations, presupposes an ideal mating between the understanding of the unconscious and therapeutic change, in which the latter is seen as a consequence of insight, in accordance with the classical interpretation given to Freud's affirmation of the *Junktim* – that is, of the inseparable bond between cure and research.[11]

Yet Freud was perfectly aware at this time that observance of the rule of evenly suspended attention created a genuine tension between the search for the truth of the unconscious and the utility of the knowledge thus obtained:

> One of the claims of psycho-analysis to distinction is, no doubt, that in its execution research and treatment coincide; nevertheless, after a certain point, the technique required for the one opposes that required for the other.
>
> (Freud, 1912, p. 114)

More is in my view gained if we accept that the unity of insight and treatment is not regarded as an *a priori* characteristic of the psychoanalytic method, but instead as a unity in the course of achievement, meticulously *constructed* by the analyst in the manner of a craftsman, day by day, in the sessions with the patient. Of course, this construction may be appropriate or otherwise; it may give rise to therapeutic change for better or for worse. Equally, this construction is co-determined in a continuous process by the patient's verbal and non-verbal action and by his reaction to our verbal and non-verbal interventions.

At the back of their minds, all analysts have specific models of the therapeutic change that is desirable and feasible for each patient – that is, theories concerning the strategies that will have the effect of bringing about these changes (Sandler and Dreher, 1996). In each transaction with his patient, the analyst decides on the best way of intervening or encouraging a small change on the road to cure in the patient. In this complex operation, the analyst is guided by many (partly) learned rules, which he endeavours to apply as best he can. In addition, he possesses working models that enable him to evaluate the impact of his interventions and permit the correction of any adverse side-effects they may have. In a word, the analyst is concerned not only with listening to the unconscious, but also with the regulation of the patient's psychic equilibrium and with the therapeutic relationship moment by moment, so as to preserve an optimum level of regression both in himself and in his patient. Of course, the concrete technical form assumed by all this will depend on the theories which the analyst has at his disposal – both explicit and, in particular, implicit theories – on the value and function of each of these variables for each individual patient at a given moment in the analysis.

The figure of the craftsman is a valid description of the analyst in this conception of his work. Like a craftsman, the analyst stands mid-way between concept and

[11] "In psycho-analysis there has existed from the very first an inseparable bond [*Junktim*] between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results. Our analytic procedure is the only one in which this precious conjunction is assured. It is only by carrying on our analytic pastoral work that we can deepen our dawning comprehension of the human mind. This prospect of scientific gain has been the proudest and happiest feature of analytic work" (Freud, 1927, p. 256).

precept. For example, let us imagine a successful piece of craftsmanship: a beautiful spoon carved in the shape of a hand. To make it, the craftsman gave form to the phantasy of the instrument as a prolongation of the human body. There is an isomorphic relationship between the hand and the spoon – that is, a relationship of form and function, which coincide and are the product of the various operations made manifest by the craftsman's aesthetic sense. If the carving is defective – for instance, if the cavity is not deep enough – the isomorphism will be imperfect, the spoon will be useless, and it will forfeit its beauty. The analyst listens through the intermediary of the operational models evoked by the signals transmitted by the patient. On the basis of the working models and of the reality of the patient, the analysing mind, also guided by the aesthetic sense, constructs equivalences that are capable, in a single movement, of combining understanding and treatment, knowledge and utility. The structuring of the analytic situation presents a 'scale' model of the intersubjective reality involving patient and analyst. This 'scale', or reduced model, is not a mere projection of the object. The working model of the patient constructed by the analyst for himself is a *real* intersubjective experience, whereby immediate knowledge of the patient's functioning can be achieved: what matters here is the relationship between the parts, which is at once intelligible in a scale model. In the analytic scale model (the analytic situation), the analyst seeks isomorphisms between models of early development, transference models, and psychopathological models: he communicates these isomorphisms to the patient, guided by the idea that, where it is a matter of resolving conflicts, it is better to know than not to know. Hence each successful interpretation gives the patient a new tool.

A craftsman will normally use limited amounts of materials and theoretical and practical instruments in order to create his works. Similarly, the analyst utilizes heterogeneous information, accumulated during his training and experience, which must be creatively *adapted* to each concrete case. Analytic work thus comes to resemble a recycling process. In our craft of psychoanalysis, our norm is the use of pre-existing *materials* (working models, partial theories, and schemata). The combination of evenly suspended attention and free association facilitates the moment-by-moment, spontaneous *evocation* of these models in the dyadic interaction. The work is guided by the analyst's theories or meta-models concerning the 'best way' of psychoanalysing. In a word, I am describing the constructivistic, second-hand nature of clinical work, whereby the analyst uses heterogeneous raw materials – that is, ones that are diverse in their origin and nature.

Any investigation of the operational models of the analyst's mind, especially in cases where 'elegant' work is not possible, will certainly throw more light on the cognitive processes of analysis and on the *real* conditions under which the psychoanalytic model operates. Here we encounter a heuristic theme – that is, the processes of creation of new psychoanalytic knowledge, which has historically arisen through the various attempts to extend the range of application of the method to groups of patients with whom the established techniques do not work. Yet it is very probable that the model I am putting forward applies to any analyst, because, regardless of the scope or explanatory force of the theories that an analyst may use, there are always areas of scepticism: "Nobody *really* knows. Even the more consistent thinkers practice inconsistently and in ways that are personal and idiosyncratic. There are many uncertainties" (Hamilton, 1996, p. 317). It may be more accurate to say that, in his daily work and having regard to the decisions he is constantly taking, every analyst is immersed

in uncertainty, precisely while waiting for the validation accorded by the patient to his conjectures and theories. What surely varies from analyst to analyst is the implicit use made by each of the explicit theories at his disposal.

At this point, the model of the craftsman must yield to the figure of the artist. At the moment when the analyst decides to intervene and chooses a particular interpretation from a diversity of possibilities, he takes a risk, which, although to a greater or lesser extent calculated, nevertheless constitutes a leap into the void. This is a singular and unique artistic moment which involves and demonstrates the complexity of the analyst's person and which transcends any theory or technique, whether explicit or implicit: it is praxis itself. This of course concerns the freedom of the analyst, his spontaneity, and his style.[12]

A deeper study of the real conditions of operation of the psychoanalytic method, and clarification of the way in which the various components of the analysing mind interact, will help us to achieve greater integration in psychoanalytic knowledge. In addition, this research will reveal that "pluralism in psychoanalysis is not simply a matter of divergence among analysts, but also a mode in which some individual analysts attempt to operate" (Hamilton, 1996, p. 310).

Dedication

This paper is dedicated to Helmut Thomä.

Translations of summary

Theoretische Pluralität und Pluralismus in der psychoanalytischen Praxis. Der Autor erläutert zunächst, dass die gegenwärtige Situation der Psychoanalyse durch eine wachsende theoretische und klinische Diversität charakterisiert ist. Das Ziel des Beitrags besteht darin, die Auswirkungen des theoretischen Pluralismus auf die klinische Praxis eingehend zu untersuchen. Der Autor beschreibt, dass dem Analytiker, von der gleichschwebenden Aufmerksamkeit abgesehen, wesentlich mehr durch den Kopf geht, wenn er in der Sitzung mit seinem Patienten arbeitet, und führt sodann sowohl ältere als auch aktuellere Beiträge an, die sich mit ebendiesem Thema beschäftigen. Er vertritt die Ansicht, dass das Thema bislang vorwiegend aus der Perspektive einer einzelnen Person bearbeitet wurde. In diesem Zusammenhang und auf der Grundlage von klinischem Material versucht er zu zeigen, wie sich vor dem Hintergrund der "impliziten Verwendung expliziter Theorien" ein fortlaufender Entscheidungsprozess im Analytiker vollzieht, der durch die Aktion und Reaktion des Patienten mitbestimmt wird. In seiner Analyse einer Sitzung führt der Autor die Konzepte der theoretischen Vernunft und der praktischen Vernunft ein. Er vertritt die These, dass sämtliche Theorien, die dem Analytiker implizit oder explizit durch den Kopf gehen mögen, gegenüber praktischen Erwägungen in den Hintergrund treten werden. Im gleichen Gedankengang beschreibt er die Validierung im klinischen Kontext als einen singulären, breit gefächerten und kontinuierlichen Prozess der sozialen und sprachlichen Ko-konstruktion der intersubjektiven Realität zwischen Patient und Analytiker. Dieser Prozess umfasst Aspekte der wechselseitigen Beobachtung sowie der kommunikativen und pragmatischen Validierung. Abschließend vertritt der Autor die Ansicht, dass die Metapher des Handwerkers den Analytiker in dieser Konzeption seiner Arbeit am treffendsten beschreibt.

Pluralidad teórica y pluralismo en la práctica clínica. El autor empieza por caracterizar la situación actual del psicoanálisis como la de una creciente diversidad práctica y teórica. El propósito de este artículo es considerar en profundidad el impacto de la pluralidad teórica sobre la práctica clínica. Después de señalar que el analista tiene mucho más que la libre atención flotante a la hora de trabajar con su paciente en la sesión, el autor analiza aportes tanto del pasado como recientes respecto a qué es lo que el analista tiene en mente cuando está trabajando con un paciente. Sugiere que el tema ha sido abordado sobre todo desde la perspectiva de una sola persona. En este sentido, y en base a material clínico, intenta demostrar cómo en la mente del analista se da, contra el telón de fondo del "uso implícito de teorías explícitas", un proceso continuo de toma de decisiones codeterminado por la acción y reacción del paciente. En su análisis de una sesión, el autor introduce los conceptos de razón teórica y razón práctica, y sostiene que, no importa cuáles sean las teorías que el analista pudiera tener implícita o explícita-

[12]Etymologically, the word *praxis* means not only action, activity, or performance, but also manner of working or being. In other words, when we speak of analytic practice, we are referring to the analyst's style.

mente en su mente, ellas en última instancia ceden a razones prácticas. Siguiendo la misma línea de pensamiento, describe la validación en un contexto clínico como un proceso único, amplio y continuo de co-construcción social y lingüística de la realidad intersubjetiva entre paciente y analista. Este proceso incluye aspectos mutuos de observación y de validación comunicativa y pragmática. En conclusión, sugiere que la figura del artesano es una descripción apropiada del analista en esta concepción de su trabajo.

Pluralité théorique et pluralisme dans la pratique psychanalytique. L'auteur commence avec le constat que la situation actuelle de la psychanalyse est caractérisée par une diversité théorique et pratique croissante. Le but de cet article est d'étudier à fond l'impact de la pluralité théorique sur la pratique clinique. Après avoir noté que l'analyste a bien plus qu'une attention également flottante dans son esprit lorsqu'il travaille en séance avec le patient, l'auteur passe en revue les anciennes et les plus récentes contributions sur la question de savoir ce que l'analyste a dans l'esprit lorsqu'il travaille avec un patient. Il considère que la question a été abordée principalement du point de vue d'une seule personne. Dans cette perspective, et sur la base du matériel clinique, il essaie de montrer comment, à contre-courant d'un arrière-fond d' « utilisation implicite de théories explicites », un processus continu de prise de décision prend place dans l'esprit de l'analyste, co-déterminé par les actions et réactions du patient. En analysant une séance, l'auteur introduit les concepts de raison théorique et de raison pratique, et soutient que, quelles que soient les théories que l'analyste a, implicitement ou explicitement, dans son esprit, celles-ci obéissent en définitive à des raisons pratiques. En poursuivant la même ligne de pensée, il décrit la validation dans le contexte clinique comme un processus singulier, large et continu de co-construction sociale et linguistique de la réalité intersubjective entre le patient et l'analyste. Ce processus inclut des aspects mutuels d'observation et de validation communicative et pragmatique. En conclusion, il suggère que la figure de l'artisan est une description appropriée de l'analyste dans la conception de son travail.

Pluralità teorica e pluralismo nella prassi psicoanalitica. L'autore inizia con il definire l'attuale situazione nel campo della psicoanalisi come caratterizzata da una crescente diversità teorica e pratica. Scopo di questo lavoro è di considerare in profondità l'impatto della pluralità teorica nella prassi clinica. Dopo aver considerato il fatto che, nella seduta terapeutica, il lavoro psichico di un analista vada molto più in là della semplice 'attenzione uniformemente sospesa', l'autore passa in rassegna contributi passati e recenti per definire i processi mentali dell'analista nel processo terapeutico con il paziente. L'autore suggerisce che questo argomento sia stato affrontato principalmente partendo da prospettive individuali. Sulla base di questa considerazione e servendosi del materiale clinico più rilevante, egli tenta di dimostrare come, sullo sfondo dell' 'uso implicito di teorie esplicite', un costante processo decisionale, co-determinato dalle azioni e reazioni del paziente, abbia luogo nella psiche dell'analista. Muovendo dall'analisi di una seduta, l'autore introduce i concetti di ragione teorica e ragione pratica e sostiene che, a prescindere dalle teorie che l'analista ha implicitamente o esplicitamente in mente, queste finiscono per cedere il passo a ragioni pratiche. Proseguendo su questa linea di pensiero, egli definisce la validazione nel contesto clinico come un individuale processo, continuo e di vasto campo, di co-costruzione sociale e linguistica della realtà intersoggettiva fra paziente e analista. Questo processo comprende aspetti reciproci di osservazione e di validazione comunicativa e prammatica. In conclusione, egli suggerisce che quella dell'artigiano sia un'immagine appropriata per descrivere come l'analista concepisca il suo lavoro.

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