Is There a Future in *Dis*illusion? Constructionist and Deconstructionist Approaches in Psychoanalysis*

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In his 1953 review of John Bowlby's *Maternal Care and Mental Health*, Winnicott (1989) writes:

> I think Bowly has omitted reference to the change-over from a relationship to a **subjective** object to a relationship to an object that is **objectively perceived** .... This disillusionment process belongs to health, and it is not possible to refer to an infant's loss of object without referring to the stage of disillusionment, and to the positive or negative factors in the early stages of this process which depend on the capacity of the mother to give the baby the illusion without which disillusionment makes no sense (p. 429).

While both illusioning and disillusioning, constructionist and deconstructionist 1 , elements are necessary in any optimally functioning analytic therapy, in contemporary psychoanalysis we may have become so focused on the responsibility that we, like mothers, have to provide illusion, that we are in danger of forgetting that we also share her responsibility to *disillusion* for, as Winnicott (1989) reminds us: "In terms of the earlier stages of the individual's integration ... the mother (in particular) plays her role as the one who disillusions her infant" (p. 145).

I. What is Psychoanalysis?

In the concluding paragraph of their Preface to *Freud and Beyond: A History of Modern Psychoanalytic Thought*, Mitchell and Black (1995) write as follows:

> The story is sometimes told that in the last years of his life one of the most important innovators in post-Freudian psychoanalysis had taken to bringing a gun with him when he presented his work at more traditional institutes. He would place it on the lectern without comment and proceed to read his paper. Invariably someone would ask about the gun, and he would say, in a pleasant voice, that the gun was for use on the first person who, rather than addressing the ideas he was presenting, asked instead whether they

were "really psychoanalysis" (p. xxiii).

Whereas Mitchell and Black appear to approve of this analyst's oddly aggressive and intimidating appeal for tolerance, allow me to register my disapproval through a partial identification with the aggressor. It is only partial because although having learned from experience I may well steel myself, I do not arm myself before presenting to psychoanalytic colleagues. But if I did decide to pack a gun, it would be for use on the first person who suggested that raising this question, whether this or that theoretical or technical approach is "really psychoanalysis," is somehow illegitimate or intellectually out of court. For it is a peculiar type of intellectual tolerance that is based on a prohibition backed by intimidation against raising certain questions, especially questions concerning the fundamental nature and defining features of our discipline and practice.

When, a few years ago, I was asked to teach a course on termination to the fourth-year candidates at one of our Institutes, my initial reaction was, to be honest, less than enthusiastic. The topic and its associations with finitude, separation, terminal illness and death, held little appeal. But as I surveyed the literature in the area in preparation for the course, I discovered that it raises all the most difficult, because they are the most fundamental and therefore the most suppressed and evaded, questions in our field. For how are we to know when our work is more or less complete unless we know what it is that we are working at? How are we to know when it is time to terminate unless we know what are the goals we set out to accomplish? How can we tell whether or not the patient is cured, or even whether an analytic process has taken place, unless we have some idea as to the defining features of the latter and, further, some notion as to how to distinguish an analytic cure from one brought about by suggestion, conversion, transference, support, or Paxil?

So, here we are, faced with the terrible, fundamental issues: What is psychoanalysis? How is analytic therapy distinguished from non-analytic therapy? What are the goals of psychoanalysis? How does it work? What is it about the therapeutic relationship and dialogue that contributes to or detracts from the achievement of genuinely psychoanalytic aims? Unless we have some answers to such questions, however tentative and approximate, we are in no position to be able to answer such practical questions as whether analytic progress is or is not being made; whether the analysis is helping or harming; whether the patient is or is not ready for termination; or whether what is taking place is really psychoanalysis or some other form of more or less useful psychotherapy.

II. Illusioning or Disillusioning?

Certainly both Sigmund Freud and Melanie Klein gave pretty clear answers to these questions. They viewed psychoanalysis and analytic, insight-oriented, dynamic or uncovering psychotherapy as treatments for emotional disorder. And they viewed functional emotional disorders as conditions in which the patient's relationship to reality, his or her *reality-testing*, is, to a greater or lesser extent, impaired. Both Freud and Klein viewed neurotics and psychotics, their followers subsequently included borderlines as well, as captured or "possessed" by a range of positive or negative illusions or phantasies which distort their relationship to the things, events and people around them. Patients were viewed as, to varying degrees, estranged from reality due to the operation of a wide range of distorting psychological processes such as repression, reaction-formation, displacement, transference and projection, to mention but a few of such defensive processes.

Since psychopathology was viewed as a condition in which one suffers from illusions, therapy was conceived as dis-illusioning, that is, as helping patients to fight free of their distorting transferences, projections, pathological identifications and irrational beliefs. Since pathology was seen as mistaking phantasies or feelings for facts, therapy aimed at enhancing reality-testing by helping patients become acquainted with their phantasies and feelings and their potentially distorting effects. In all this, there was no denial of the fact that therapists too have illusions and confuse reality and phantasy. Freud referred to the therapist's distorting transference as *countertransference*and the Kleinians came to include under this rubric the emotional effects induced in the analyst by the analysand's projective identifications as well. The traditional psychoanalytic insistence that analysts themselves undergo analysis as a precondition of practice is based on this recognition.

In these respects, Freud and Klein and their followers were operating, broadly speaking, as rationalists, heirs of the Enlightenment. But theirs was a chastened rationalism, tempered by romanticism's recognition of the irrational depths of human nature. But, however qualified in this respect, it was a rationalism determined to subject the irrational to a rational inquiry that, through knowing it, would disarm and subject (or at the very least sublimate or redirect) it and bring it under an overall *dictatorship of reason*. By definition, this was expected to be a *reasonable dictatorship*, reasonable enough to give the passions and the unconscious their due or, as William Barrett (1958) put the point in a Postscript to his classic account of existentialism, *Irrational Man*, to allow "a place for the Furies" lest the

ancient mother-goddesses rise up and destroy the temple of reason altogether. In light of this recognition, it would seem that the Freudian ideal is in reality less a dictatorship than a kind of fragile and precarious democracy, less a matter of the dominance of the ego over id and superego, or of Apollo over Dionysus, than of their integration, an adaptive compromise or equilibrium worked out, nonetheless, under the overall supervision of the rational ego.

Freud, Klein and their followers were *disillusionists*, practitioners of what Nietzsche called the *art of mistrust*. Along with Marx, Sartre and, of course, Nietzsche himself, they belonged to the Western *tradition of suspicion* (Remmling, 1967) whose adherents sought emancipation from the idols of the age by unmasking the *false consciousness* and dominant ideologies that are the collective equivalent of the personal illusions and delusions, the wishful thinking, transferences and projections that distort the neurotic individual's relation to reality.

In a wider sense, such *disillusionism* belongs to what in various spiritual traditions is known as the *via negativa* or negative path wherein salvation or enlightenment is achieved less by direct discovery and affirmation of *the truth* than by seeing through the veil of *Maya*, the pseudo-truths that we mistake for it; less through knowledge (*gnosis*) of the one true faith than by transcending the counterfeit creeds that stand in the way of any genuine salvation by faith and by grace; and less by direct discovery of the *true self* than by fighting free of the *false selves* that are its masquerades.

The disillusionist spirit is captured nicely in the title of Erich Fromm's (1962) *Beyond the Chains of Illusion: My Encounter with Marx and Freud*. The notion of liberation as breaking the chains of illusion fits nicely with the saying, "And you shall know the truth; and the truth shall make you free," which sounds as if it might have been penned by Marx or Freud but is actually attributed to Jesus (*John* 8:32). Understood in the Hebraic sense as a truth of the heart and not merely in the Hellenistic sense as a truth of the intellect, I think it is congruent with Bion's conception of truth as the essential nutriment of the mind. According to the Symingtons (1996):

> O is the truth which can be known through the medium of science, religion or art. Different facets of O are known through these different media. When O emerges in the psychoanalytic process, contact is made with that ultimate reality which illuminates the sciences, religion and art. Bion made contact with O through the medium of psychoanalysis, but his ultimate concern was with O

and not the vehicle through which it was approached. His concern
went deep into the sinews of existence (p. 181).

And, like Freud himself, Bion had a deep sense of the profound *resistances*
in both the individual and, even more so, in the group to the emergence of
such truth.

For workers in the tradition of suspicion therapeutic progress is judged in
terms of advancing dis-illusionment. Are our patients succeeding in
progressively overcoming their resistances, fighting free of their illusions
(their transferences, projections, pathological identifications, false and
distorting beliefs), and improving their capacities for reality-testing, for
distinguishing phantasy from fact, past from present, inner from outer, the
imaginary from the real, or are they not? The relative success or failure of
the treatment and the timing of its termination are judged by these criteria.

To some, even today, all this may sound obvious and more or less taken for
granted. But for others, and I think this is an ever larger group, the model
I've just presented will sound alien and perhaps even offensive. Those who
have this reaction may wish to raise a host of objections to what they regard
as the arrogance, authoritarianism, positivism, scientism, intellectualism,
medicalism, phallogocentrism and a range of other "isms" of this
perspective. For many today, the disillusionist perspective is not only
regarded as outmoded, a relic of the past, but as morally suspect, best
consigned to the dustbin of history along with the eurocentrism, racism,
patriarchal sexism, heterosexism and homophobia with which it is thought, I
believe incorrectly, to be inextricably associated.

For today a very different model of emotional disorder, therapy and cure is
becoming, or has become, dominant. It is a model in which patients or
clients are not so much seen as suffering from illusions that need to be
transcended and conflicts that need to be understood, resolved or
transformed, as from psychological deficits that need filling-in and from
arrested development that needs to be resumed.

It is important to recognize that both the therapies of construction and of
deconstruction, of identification and disidentification, recognize the role of
trauma, abuse and deprivation, among other factors, in the genesis of
emotional disorders. In my opinion, it is simply incorrect to reduce the
difference between the *therapies of faith* and the *therapies of doubt* to that
between perspectives favouring nurture and those emphasizing nature in the
genesis of psychopthology, or to identify the disillusionist approach with a

now outmoded drive theory2 that evades recognition or underplays the significance of environmental factors in pathogenesis.

But while certainly acknowledging environmental factors, in the traditional, deconstructionist approach trauma, abuse and deprivation are seen as generating anxiety, rage, guilt, conflicts, defences, transferences and projections in need of *analysis*. In contrast, in the increasingly pervasive constructionist or synthetic (as distinct from analytic) therapies, such factors are viewed as generating psychological defects, deficits and arrests that require the therapist's *provision* of the psychological and emotional nutriment of which the patient is thought to have been deprived and hence lacks, and provision of a climate in which arrested development may be resumed, this time in the presence of and under the benign influence of the therapist.

In this latter framework, what is considered therapeutically essential is not the therapist's provision of insight or self-knowledge leading to self-mastery. Rather it is the provision of *corrective emotional experiences* (Alexander & French, 1946) of *holding* (Winnicott, 1960b, 1962) or *containment* (Bion, 1962), *empathicunderstanding*, *affect attunement*, *selfobject responses* to mirroring and idealizing needs, and *optimal responsiveness* (Bacal, 1985) as distinct from *optimal frustration* (Kohut, 1978), opportunities to *internalize a good object* (Klein, 1959) and to form *positive identifications* and the *transmuting internalization* (Kohut, 1978) of such experiences by the patient that is held to be curative. Under the conditions of safety, understanding and positive responsiveness provided by the therapist, the structural defects and deficits resulting from trauma, deprivation and arrested development are thought to be filled in and new, healthier structures based on positive internalization and identification with the empathic and optimally responsive therapist are thought to be developed.

In this perspective, therapy is less a matter of removing pathogenic *presences* (anxieties, phantasies, illusions, transferences, projections, etc.) than of filling in or compensating for pathogenic *absences* (the deficits and arrests resulting from environmental failure in childhood). Essentially, the damage done by parental deficiency, deprivation, impingement or outright abuse is to be corrected through internalization of the therapist's goodness. However much it may be denied, this newer model is clearly one of therapy as a kind of *reparative reparenting*.

Without digressing into an historical account of how this shift in the

conception of pathology and cure came about, suffice it to say that although the displacement of the insight/mastery model by the corrective emotional experience or reparenting model is most evident in such approaches as those of Guntrip (1971) and Kohut (1978) and their followers in relational psychoanalysis and self psychology, it has its roots both in certain aspects of Winnicott's (1960b, 1962) wonderfully inconsistent theorizing (the Kleinian and even Freudian elements were never disavowed despite the increasing privileging of illusion over disillusion and the gradual shift to a model of provision rather than analysis) and in psychoanalytic ego psychology. Although Freud himself took the fateful step of introducing the metaphor of *structure* into his psychology, he himself never allowed the notions of structural defect and deficit to displace his fundamental conception of pathology as rooted in conflict, phantasy and distortion and, hence, of the cure as conflict-resolution, reality-testing and mourning. But following the extension of Freud's structural thinking by Hartmann (1939) and the latter's introduction of an *adaptive* point of view emphasizing the importance in development of an *average expectable environment* (Winnicott's *facilitating environment*), pathology came increasingly to be conceptualized as structural defect, deficit and developmental arrest arising from environmental failure.

Paralleling this development was a concomitant subtle and gradual shift in the understanding of the therapeutic process, away from conflict-resolution through insight, reality-testing, mastery and mourning and toward a model emphasizing the therapeutic provision of corrective emotional experiences in which defects and deficits are filled-in through transmuting internalization and identification, and in which developmental arrests are overcome through the resumption of normal development in the context of and under the benign influence of the therapist *in loco parentis*.

It is not my wish either to polarize these models or to too easily set aside their fundamental and real differences by leaping to the dialectical logic of both/and rather than either/or. I believe that therapeutic provision is necessary, but insufficient, to bring about therapeutic disillusionment. In order for the latter to occur, a therapeutic or working alliance entailing an atmosphere of safety and trust, including confidence in the therapist's reliability, empathy, affective sensitivity and respect, must first have been established. In addition, any therapy that enables the patient to arrive at genuine insight and self-knowledge must in itself be regarded as a type of corrective emotional experience. But I believe that, today, the conditions or means to the end of therapeutic disillusionment -- *including the necessary and strategic provision of illusion in the earlier phases of work with more*

disturbed patients -- are in danger of becoming ends in themselves.

III. *Via Negativa*

Back in 1980, Robert Langs published his provocative essay, "Truth therapy/lie therapy." He argued that all the various criteria by which we might distinguish different types of talk therapy -- supportive vs. analytic or dynamic; expressive vs. uncovering; empathic vs. interpretive; intrapsychic vs. interpersonal; one-body vs. two-body; etc. -- pale in significance in relation to the more fundamental distinction between therapies that are fundamentally directed toward uncovering, facing and working-through maddening memories, phantasies, wishes and feelings ("truth therapy") and those that seek to help by shoring up defenses against such disturbing contents ("lie therapy").

Although he acknowledged a role for lie therapy and recognized its helpfulness in certain contexts, Langs sought to clarify the status of psychoanalysis as a truth therapy, as Freud himself certainly conceived it. If I am uncomfortable with the notion of "truth therapy," this is certainly not because, in the spirit of a currently fashionable postmodern epistemological relativism, I wish, like Pilate, to ask "What is truth?" and wash my hands, but because, although truth exists, it is very hard to come by. Making its attainment the goal of therapy smacks, to me, of *hubris*. So I prefer the *via negativa* in which therapy is less a matter of arriving at The Truth, than of clearing the path toward it by removing a whole host of pseudo-truths, illusions or delusions (idols in other words) that pass for it and that block the way to its progressive approximation.

That last phrase is reminiscent of Sir Karl Popper (1972) and I recognize a parallel between what I'm saying here about analysis and what he said about science -- namely, that it is less a matter of verification than of falsification, less a matter of achieving absolute knowledge of the truth, than of progressively approximating an ultimately incompletely knowable reality through a never-ending process of eliminating errors and illusions. With this in mind, I propose that we substitute for the distinction made by Langs (truth therapy/lie therapy) that between therapies, on the one hand, that *in the long run* seek to deconstruct and disillusion and those, on the other, that are content to construct or illusion. Whereas the disillusionist seeks ultimately to negate, falsify, debunk, deconstruct and invalidate[3] various beliefs or phantasies considered pathogenic, the illusionist, engaging in a very willing suspension of disbelief, seeks to, at the very least, acknowledge the plausibility of, if not to affirm, confirm or validate, various constructions

deemed to be of therapeutic benefit to the patient (and not merely as a temporary means to the long term goal of disillusion). Whereas the constructionist seeks to inspire a new or a renewed faith, either by affirming the patient's narratives and metaphors or by jointly working out more useful ones, the deconstructionist aims (ultimately) to cast a critical and skeptical eye upon every narrative and metaphor without exception with a view to assisting the patient to cease to be a believer, even to liberate him or her from belief as such.

Recently I came across the following statement by Thomas Ogden (1989, p. 2) that nicely captures the spirit of this attitude toward clinical psychoanalysis:

> It is necessary that both the analytic discourse between analysts and the analytic dialogue between analyst and analysand serve as "containers" for the experience of confusion and not knowing. If all is going well in the analytic process, the analysand will inevitably complain that he understands even less at present than he did at the beginning of the analysis. (More accurately he understands less than he *thought* he knew at the outset of the analysis, and he is learning to tolerate not knowing.)

Here, of course, the sort of "knowing" and "belief" that must be therapeutically surpassed refers to what may otherwise be described as dogma, ideology or reification, or as an alienated or undialectical consciousness (characteristic of what Klein called the paranoid-schizoid position.) It concerns the human proclivity to take one's stories and oneself entirely seriously, thus succumbing to what Nietzsche called the *spirit of solemnity* characteristic of those whom Jean-Paul Sartre called *les salauds* (a difficult term to translate, although perhaps "the bastards" or "stuffed shirts" will suffice).

Parenthetically, it should be emphasized that if, for the disillusionist, it is important not to believe in anything, it is even more important not to believe in *nothing*. That is, if one opts for the deconstructionist approach it must be carried out consistently, to the point at which one becomes disillusioned even with one's disillusionment. Nihilism is still an "ism", a belief system, as much in need of deconstruction as any other. As Eliot (1950) says, "Disillusion can become itself an illusion if we rest in it" (p. 136). In other words, deconstruction as a therapeutic method is not just about dismantling the manic defense against depression; it is about dismantling (i.e., analyzing and resolving) the underlying depression as well. In this sense, it should be

clear that *deconstruction* is not to be confused with *destruction*.

IV. Gnostic or Agnostic?

In 1927, Freud, the great disillusionist, published *The Future of An Illusion*, which raised the question of the survival of religion in the age of science. Now, in the terminal phase of the century and the millennium, we are faced with the question of the survival, not of religion, but of the very tradition of suspicion that challenged its conventional forms. Today, the heirs of the Enlightenment seem ever more feeble in their capacity to critique the secular ideologies or "antitheologies" which, however manifestly irreligious, nevertheless function as "surrogate faiths" that attempt, however inadequately, to fill the vacuum and palliate the "nostaligia for the absolute" (Steiner, 1974) arising from the the "death" (Nietzsche, 1882, section 125; 1886, section 343) or at least the "eclipse" (Buber 1952) of God in Western culture. In this light, it is evident that, against Freud's prediction, religion has had and continues to have a future, if not in its traditional forms then in that of the "the triumph of the therapeutic" (Rieff, 1966).

Ironically, at the same time as the secular substitute religions of psychotherapy that operate through inspiration, identification and conversion (the transference cure) enjoy increasing influence, at least among that portion of the population still interested in a *psyche* irreducible to somatic (neurochemical) processes, critical reason (as distinct from merely instrumental or technical rationality) is itself threatened on all sides. In this context, psychoanalysis, the form of psychotherapy traditionally most allied to the Enlightenment spirit of critique, is itself in danger of being eclipsed, in psychiatry by biological reductionism, and in the field of psychotherapy by fundamentally irrationalist, romantic and revisionist therapeutic religions, some of which nevertheless insist upon their right to advertise themselves in the therapeutic marketplace under the psychoanalytic "logo" even while having long abandoned any psychoanalytic *logos*.

I find it useful to think of the conflicting therapeutic strategies of today less in terms of truth and lie than of *agnostic* versus *gnostic* therapy, the therapies of enlightenment through disillusion wrought through doubt and the deconstruction of belief, versus essentially religious therapies offering salvational belief ("saving knowledge" or *gnosis*) or a renewal of faith. Here, of course, I am employing the terms religion and faith, both in the conventional sense of the dogmas and practices of churches, synagogues

and temples, and also with reference to a psychological or spiritual healing, a "cure of souls" or a "restoration of the self" achieved, not through the arts of suspicion and disillusion, but through a renewal of faith or belief -- in some Other, or others, or in one's "self" -- through connecting or reconnecting to some community of belief or milieu of "selfobject responsiveness."

I do not wish to leave the impression that I think of all religion and mysticism and spirituality as illusioning. That is one, perhaps the dominant, type of religiosity. There is another disillusioning or antinomian type of religion. Here we have, for example, the so-called "death of god" theology (Vahanian, 1957; Altizer, 1970) that welcomes the collapse of the old faith for it is seen as idolatrous in any case. In so-called "religionless Christianity" (Bonhoeffer, 1953) for example, it is held that atheism as loss of faith in the pseudo-god of superstition and supernaturalism is an essential precondition of development toward a mature faith, for the old deity was merely an idol in any case, a graven image that stood in the way of recognition and worship of the living God. Such antinomian forms of spirituality are profoundly disillusioning, but not in the service of positivism or superficial atheism, but out of loyalty to what Paul Tillich (1952) called "the God above God."

I think we see this antinomian type of spirituality not only in religionless Christianity, but in Buddhism, for example, and a wide range of other spiritual traditions, disciplines and practices. Like Epstein (1995), I believe disillusionist psychoanalysis shares with certain Buddhist traditions a common commitment to the *via negativa* in which systematic deconstruction and disidentification promote a condition of non-attachment to every idolatrous image of the self and others. Here again, let us recall Ogden's (1989) belief that "If all is going well in the analytic process, the analysand will inevitably complain that he understands even less at present than ... he *thought* he knew at the outset of the analysis, and he is learning to tolerate not knowing" (p.2). I think this parallel becomes most evident in Lacanian psychoanalysis which seeks (or at least is supposed to seek) to systematically dismantle the Imaginary specular "ego" (composed of all the images, representations and narratives that compose the self as idol) in favour of the emergence of the living "subject" that I think in some ways parallels Winnicott's (1960a) "going-on-being" understood not reductively as referring exclusively to our psychosomatic existence, but existentially with reference to our *ex-istence* as symboling and self-reflexive human subjects (Heidegger's [1962] *Dasein*).

It is not my purpose here to go into the intricacies and obscurities of Lacanian psychoanalysis, religionless Christianity, Zen Buddhism or existentialism, so let me attempt to clarify the fundamental distinction that I do wish to emphasize -- that between gnostic or constructionist therapies that operate primarily through processes of *identification*, and agnostic or deconstructionist ones that operate primarily through processes of *disidentification*. This, of course, is an analytical distinction, which means that in reality any therapy is likely to be a mixture containing both identifying and disidentifying elements in varying proportions. Certainly agnostic, deconstuctionist or disidentifying therapy depends for its existence and effectiveness upon the presence in the therapy of gnostic, constructionist and identifying elements. For any therapy to work there must exist a working or therapeutic alliance, an atmosphere of safety, some degree of basic trust or faith in the therapist and the process, and some considerable degree of shared belief or "knowledge" of what therapy is, what the respective roles of therapist and patient are, what goals they are working together towards, and so on. All this implies a degree of co-construction of the therapeutic space and process and an inevitable element of mutual identification. Beyond this, in work with more seriously disturbed patients, the provision of therapeutic illusion may be necessary for a considerable time before therapeutic disillusion becomes a possibility. For if, as Eliot (1944) writes, "human kind cannot bear very much reality" (p. 8), then such patients can, initially at least, bear even less.

But while I would suggest that deconstructionist or disidentifying therapy requires a backgound of constructionist and identifying elements, these are necessary but insufficient to qualify the therapy as deconstructionist. For a therapy to constitute itself as *agnostic* (a therapy of doubt) as distinct from *gnostic* (a therapy of belief), it must move beyond this background of identification towards the disillusionist task. Like Winnicott's mother, it must move beyond the phase of providing illusion toward that of providing a corrective emotional experience of therapeutic disillusion and disidentification. Nothing less is "good enough." From a deconstructionist point of view, the problem with constructionist therapies is that they mistake the necessary conditions of analysis for analysis itself.

The following table is an attempt to characterize the two approaches I've been describing along a number of different dimensions.

Table 1: Two Models of the Therapeutic Process

FAITH	DOUBT

Gnostic	Agnostic
Belief	Unbelief
Illusioning	Disillusioning
Constructionist	Deconstructionist
Identification	Disidentification
Inspiration (synthetic)	Interpretation (analytic)
Corrective emotional experience	Insight
Empathic inquiry re patient's experience	Making the unconscious conscious
Validating experience and the truth content in distortions and delusions	Overcoming self-deception and distortion and enhancing reality-testing
Empathy as an end in itself	Empathy as a means to an end (insight)
Pathology as deficit, defect and arrest	Pathology as conflict and distortion
Pathogenic absences	Pathogenic presences
Work within the metaphor or phantasy	Work outside the metaphor or phantasy
Therapy as provision	Therapy as analysis
Treat *the child within*	Deconstruct the phantasy of *the child within*
Help patients to integrate their multiple selves	Promote disidentification from the phantasy of being multiple
Repair developmental deficits and defects through *transmuting internalization* of the empathic analyst	Promote disidentification from the phantasy of deficit and defectiveness
Help patients resume arrested development toward adulthood through a process of reparenting by the therapist *in loco parentis*	Promote recognition by patients that they are adults and their therapists are their employees
Relationship as healing (dyadic)	Relationship as revealing (triadic)
IMAGINARY	**SYMBOLIC**

In a workshop following a presentation of this paper, a participant noted that

I seemed to identify with and privilege the agnostic over the gnostic approach. She wondered whether this identification required disidentification and whether my privileging of disillusion over illusion was not itself a kind of ideology or idolatry in need of deconstruction. I agreed she had a point. But I went on to add that in helping me recognize, deconstruct and disidentify from my bias, she had at the same time validated the disidentification model. She was practicing it herself and encouraging me to do the same and for this I thanked her. Keeping in mind this higher-order commitment to disillusion, I have subsequently attempted to place greater emphasis upon the necessary provision of illusion "without which disillusionment makes no sense" (Winnicott, 1989, p. 429).

V. Melting Frozen Metaphors

As a result of experiences both on and behind the couch, I early came to the conclusion that, among other factors in the therapeutic action of psychoanalysis, the insight and mastery to be obtained through the deliteralization, deconstruction, or dereification of literalized, reified, concretized, "dead" or "frozen" metaphors are central to the psychoanalytic cure (Carveth, 1984).4 When the metaphor refers to the object, its literalization turns analogy into identity and, as a result, a multi-dimensional view of the object is lost by a mind that, in this way, becomes one-dimensional. When the metaphor refers to the self, its literalization results in the one-dimensional equation of the self with some concept or image -- the paradigm case being the infant's misidentification of itself with its mirror-image in the mirror-phase (Lacan, 1977, ch. 1).

Through such experiences as helping A to see that the oral defense of his doctoral dissertation might not, in actuality, entail submission to a gang-rape and that the members of his examining committee might actually wish him well, or assisting B to understand that her lacking a penis was not equivalent to her *being* a "lack," or promoting C's recognition that employing his penis in sexual intercourse was not equivalent to the launching of a Cruise missile, I came to understand that a significant portion of the emancipatory potential of psychoanalysis lies in its power to "resurrect" or bring "dead" metaphors back to "life."

This process of turning identities back into analogies, of restoring the mental gap or space between a metaphorical concept and its object that enables us to remember that while a woman may in some ways be *similar* to a castrated man she is not one, or that while a man's wife may in certain respects *resemble* a vampire she may not literally be out for his blood, is I

believe a central ingredient of both psychoanalytic insight and the analytic cure.

Clinical Example:

> In the latter example, my patient had been speaking of his wife as a vampire for weeks while I, of course, had been assuming that he, a highly intelligent and articulate man, was intentionally and self-consciously speaking figuratively. Gradually, however, the pervasiveness and concrete quality of his metaphor began to dawn on me and I ventured to say, "Of course, she is not a vampire." His response was immediate and loud -- "But she is!" -- and he proceeded to review for me yet again the many ways in which her behaviour so eminently qualified her for this description.
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> But when, allowing that his wife might well *resemble* a vampire in some respects, I nevertheless insisted that she was not literally a monster, he saw the point and was both startled and momentarily confused. However close to psychosis he undoubtedly was at times, to his credit he proceeded not only to disengage from this particular "dead" metaphor but also to review and achieve some critical distance from a range of other metaphors that in concretized form had been controlling his thought and action. Although it in no way constituted integration and working through of the projected oral hate and envy underlying his "dead" metaphor, the fact remains that the psychic differentiation and integration entailed in its deliteralization (i.e., the progression from primary to secondary process thought or from the paranoid-schizoid to the depressive position [PS->D]), however incomplete and temporary, helped my patient to disengage from his battle to the death with his wife and enabled him to let go and walk away before either of them were, quite literally, killed.

Despite training in the method of free association and familiarity with the primary process mechanisms of condensation and displacement that Lacan (1977), following Roman Jakobson (Jakobson & Halle, 1956), recognized as metaphor and metonymy respectively, it would seem that many analysts still fail to appreciate that psychic reality, as a system of concretized and absolute (primary process) or abstract and relative (secondary process) associations of one thing with another, is a system of metaphors, "dead" or "alive."5 This fact is evident in the reactions of some colleagues to criticism

of the work of therapists whose technique appears to confirm rather than to question the "dead" metaphors central to their patients' pathology.

It is not at all rare, for example, for therapists working with patients suffering from so-called "multiple personality disorder" to implictly or explicitly affirm rather than question the patient's identification of the self with one or more figurative sub-personalities. Instead of helping the patient deliteralize the concretized metaphor that dominates him and to see that he is not literally "possessed" by various "alter-egos" but that it is only *as if* he were and proceeding to analyze the psychological meanings, functions and origins of this concretized phantasy or fiction, such therapists operate from within the metaphor rather than calling the metaphor itself into question. But while some therapists working with so-called MPD take their patients' convictions of multiplicity at face value, others argue that in order in the long run to help the patient achieve an integrated identity it is necessary in the short run to "make contact with" and at least appear to accept the "reality" of his multiple selves.

Although it certainly runs the risk of being experienced as patronizing and even dishonest, I have little doubt that in the hands of experienced and skilled clinicians who employ it judiciously, self-consciously and with full awareness of its tactical aim the technique of strategically "joining" the patient's concretized metaphor as a means of liberating him from it can be effective in promoting emotional growth (Lindner, 1950). But the self-conscious use of techniques of "joining," "taking the side of the resistance" and "paradigmatic intervention" associated with the school of Modern Psychoanalysis (Spotnitz, 1969; Marshall, 1982; Margolis, 1994) -- techniques that, as Marshall (1998) has recently pointed out, in some ways parallel self-psychological techniques of "mirroring" and "empathic immersion" -- is to be clearly distinguished from the sort of well-intentioned but excessive open-mindedness bordering on credulity that constitutes a major countertransference resistance to analysis. Ordinarily, in work with a patient who feels haunted, the analyst need not turn his sessions into seances, let alone share his belief in ghosts.

But there is little doubt that a strictly rational, interpretive technique that may be "good enough" in work with neurotic analysands is often ineffective in work with narcissistic, borderline and psychotic patients and in the face of various therapeutic impasses. In work with patients incapable, at least in earlier stages of therapy, of working on more rational levels, or in the face of various intractable narcissistic resistances, joining and mirroring techniques may sometimes be effectively employed as short-term means to

the ultimate end of rational self-understanding. I find it ironic when analytic colleagues otherwise inclined to entirely reject the use of non-interpretive techniques as unanalytic, even when deliberately and strategically employed by experienced clinicians in work with patients unreachable by unmodified analytic technique and consciously adopted as a temporary means (a parameter) to the ultimate end of rational self-understanding, themselves "join" their patients' phantasies in ways that more closely approximate a *folie-a-deux* than a considered technical means to a psychoanalytic end.

On occasion, when I have pointed out to colleagues working with so-called MPD, and who report asking to speak to this or that "alter," that in doing so they are literalizing rather than deliteralizing or deconstructing the patient's concretized metaphor, I have sometimes encountered the response that, for these patients, multiple personality is no mere metaphor, it is their *psychic reality*. While, to some, this may sound plausible, empathic, even wise, my own response is to insist that, on the contrary, metaphor is never "mere." The failure to understand that psychic reality *is* metaphor (and contrast) and that we are either controlled by our concretized metaphors (and oppositions) or purchase some degree of freedom and self-control through deliteralizing or "resurrecting" them betrays either a surprising confusion as to the nature of analytic work or a degree of comfort with the model of analysis as conversion, inspiration and identification that I personally still find startling when I encounter it in analytically trained colleagues. What is at stake is the distinctiveness of psychoanalytic technique as an essentially rational modality of psychotherapy as opposed to non-rational, shamanistic techniques of all types which, however helpful they may be in various ways, bear little resemblance to the "truth therapy" (Langs, 1980) initiated by Freud.

Like social anthropologists studying alien belief systems, analysts of all schools are vulnerable to the danger of "going native" and being recruited by the belief system they were initially aiming to analyze. (I recall anthropologist Laura Bohannan's gripping account [Bowen, 1964] of her struggle to retain some critical distance from the belief in witchcraft so central to the culture she was studying by returning to her hut each evening and reading Shakespeare.) For example, in working psychotherapeutically with cases of so-called "environmental illness," instead of retaining sufficient critical distance from the patient's belief system to be able to appreciate the strong possibility that it may at its core manifest an essentially paranoid process underlying manifestly psychosomatic or hysterical symptoms, the analyst may develop an induced countertransferential identification with the patient's belief system to the

point of actually coming to share his or her illusion or delusion--a condition Grinberg (1962, 1979) refers to as "projective counteridentification." Analysts committed to the self-psychological and so-called intersubjectivist technique of "sustained empathic immersion" (Stolorow, Brandchaft & Atwood, 1987) in the patient's subjective world may be particularly vulnerable to this countertransference problem--that is, to being unconsciously induced to extend their "willing suspension of disbelief" to at least a partial acceptance of and identification and collusion with the patient's phantasy system.

So-called "environmental illness" is peculiar in that self-diagnosed patients attribute the causes of their symptoms to a toxic environment and, in the absence of supporting scientific evidence, some practitioners agree. In a recent case reported by CBC News Online (January 8, 1999), a Toronto physician practicing what he calls complementary or environmental medicine was convicted of professional misconduct by the disciplinary committee of the Ontario College of Physicians and Surgeons. Significantly, however, the College's disciplinary committee went out of its way to state that environmental medicine was not on trial and that it was concerned only with this physician's treatment of six particular patients. Although medical authority appears to be hedging its bets with regard to so-called "environmental illness," it has not, to my knowledge, yet been willing to accept the claims of self-diagnosed patients who attribute their symptoms to alien abduction. But as the "X-files" continues to shape our cultural consciousness, medicalization of this "illness" and its "treatment" through "alien abduction therapy" may yet be in the cards. Various degrees of credulity toward and collusion with the phantasies and concretized metaphors underlying such "conditions" as "multiple personality disorder," "environmental illness," "multiple chemical sensitivity," "chronic fatigue syndrome," and the like, occur in a general medical context that is at best ambiguous with regard to their status and in a psychoanalytic subculture that, in its strong emphasis upon open-mindedness and empathic immersion and its aversion toward older therapeutic ideals of neutrality and objectivity, would seem to invite such countertransference resistance and its enactment.

There is no doubt that attempting to treat such paranoid conditions through confrontation and interpretation of their underlying projective dynamics is unlikely to succeed, at least until a strong therapeutic alliance has been achieved, such that the patient's profound anxieties and consequent resistances have been significantly alleviated. Building such an alliance is, in such cases, the major part of the therapeutic task. Accomplishing it may require years of psychotherapeutic "containment" before analysis through

interpretation becomes possible. But during this period of therapeutic containment and forbearance from confrontation and interpretation, the analyst need not succumb to projective counteridentification, but manage instead to operate more like anthropologist Laura Bohannan, both empathizing with and yet struggling to retain critical detachment from the patient's illusion or delusion, perhaps self-consciously and strategically joining it at times, all the while inwardly maintaining a critical awareness of the essentially paranoid nature of the patient's condition. If such "joining" were tactical rather than credulous or ambiguous, the treatment might either be considered a psychotherapy devoted to building the conditions in which a psychoanalysis might eventually be possible or, alternatively, as an analysis in a very early stage in which a parameter was being employed. But despite the fact that Heinz Kohut's techniques of mirroring and empathic attunement may well have been derived from his analyst, August Aichhorn (1935), who was also the originator of the technique of self-conscious and tactical joining, the latter was elaborated by Hyman Spotnitz (1969), who fully acknowledged Aichhorn's influence, and to this day it remains a Modern Analytic rather than a self psychological technique.

VI. Therapeutic Iconoclasm

Although an *iconoclastic* (breaking of the images)6 technique that, employing tactics of deliteralization, deconstruction, disillusion and disidentification, seeks to liberate Lacan's (1977) "subject" from the "ego," or Mead's (1934) "I" from the "me," or Winnicott's (1960a) "true self" (as "going-on-being") from the "false self" may, at first, appear exceptional, I suspect many analysts who may never have given any thought to these issues nevertheless do practice an essentially iconoclastic technique without recognizing it as such. I refer here to therapists for whom the "analytic attitude" is one of empathic interest in, but skeptical questioning of, absolutely every mental production of the patient without exception.

This analytic attitude may be grounded theoretically in different ways for different analysts. The Freudian ego psychologist may, with Brenner (1982), regard everything in the mind as a "compromise-formation" and, hence, as not in any way to be taken literally, but as requiring analysis. But for this to amount to an iconoclastic technique, it must be applied not merely to those of the patient's stories and images that are considered to be pathological, or outmoded, or based on transference or projection, and so on, but to all the patient's stories without exception. In other words, it must not be a matter of deconstructing scenarios considered to be neurotic

repetitions in favour of the affirmation of stories considered to be more realistic, healthy or adaptive. In the iconoclastic approach, even the latter are considered to be narrative constructs.

Similarly, many therapists working in the Kleinian tradition may have been unselfconsciously practising an iconoclastic technique. Without announcing the fact, Klein essentially transformed Freud's drive/defence or instinct/control model into a view of the mind as a phantasy system: as a kind of inner theatre in which phantasies of loving and hating, destroying and repairing, taking parts of others into ourselves and putting parts of ourselves into others constitute the dramatic action. Properly understood, for example, Klein's concept of projective identification is not a mental mechanism in the sense of Freudian mechanisms of defence. Rather, it is a phantasy of putting parts of the self into others.

Being aware, in this way, that the mind is composed of phantasy, many Kleinians are protected from the danger of reifying such phantasies and treating them as literal facts. This is not to say that such phantasies are not taken seriously. Rather, they are taken seriously as phantasies, for it is understood that our phantasies constitute the tissue of our minds and the basis of our actions. But by systematically viewing all mental contents as phantasy, such contents are systematically deconstructed and, perhaps without the therapist being aware of what he is doing, the patient is being helped to disidentify from each and every phantasy/construction, and not merely from those judged to be outmoded, unrealistic or maladaptive. Over time, such systematic disidentification may lead to the relative decentering of the (specular) ego. With the gradual disappearance of the latter from centre stage, the subject, hithertoo "upstaged" or relegated to the wings, may begin to make an appearance.[7]

I believe this is how, as therapists, we ought to be working. By this standard, I believe we fail a good deal of the time. The problem is that we are perpetually seduced into believing -- that is, into taking quite literally, concretizing or reifying -- a good deal of what our patients tell us about themselves.[8] And, of course, in saying this, I do not mean to suggest we should disbelieve our patients. If, in keeping with an iconoclastic analytic attitude, we insist that our patients' stories, like our own, are constructions of this sort, this in no way implies that they are false or untrue. Our stories differ widely in regard to their degree of plausibility. Some are certainly more plausible than others. Some appear utterly implausible. But all are stories, narrative constructions shaping our experience. Once we have entered the domain of symbolic functioning -- I am employing this term in a

wide sense that includes the registers of both the Lacanian Imaginary and the Symbolic -- we have no direct or symbolically unmediated mental access to reality.

Our experience of any reality is a construction and reality may be construed or symbolized in a variety of ways, some of which are more plausible than others. In emphasizing this point, an iconoclastic technique seeks to open up for the patient a certain critical distance between himself as a critically questioning subject and his "ego" regarded as the sum-total of his experiences -- that is, of the stories he tells himself about himself. But to insist that there is no experience apart from the constructions or interpretations that constitute it entails no necessary denial of empirical or historical reality. It is merely to insist that although "the facts" can, in a bald sense, often be known, such facts only *signify* -- i.e., acquire meaning -- through the conceptual structures with which we represent them to ourselves and others. Our experience is never direct or unmediated, but always already the product of interpretation. However, contrary to a radical, "postmodern" epistemological relativism, this in no way implies that facts do not exist, are not discoverable, or are irrelevant.

Clinical Example:

Mrs. A knew that her uncle initiated sexual activities with her when she was twelve. There was a good deal of evidence suggesting that something similar had previously occurred with her father, but there were no conscious memories supporting this; it remained an open question in her treatment. But even if such activites with the father had been confirmed, the issue would have been the same as in the case of those involving the uncle which were indubitable: namely, what stories had Mrs. A elaborated, consciously and unconsciously, to lend meaning to these events? How had these events entered her experience or been taken up by her personal myth? What *weltanschauung* had she constructed and what experiential world had she devised to endow these events with specific meaning? In other words, how had these events shaped her experience and formed her ego or self?

At the outset of her work with me, Mrs. A was very resistant to the notion that what had transpired with her uncle (and possibly with her father) could be construed as "sexual abuse." This was a reading of the facts that she rejected. She denied that she was in any sense a "victim" and was more inclined to blame herself for

what had transpired, even though she knew she had tried to avoid her uncle and that he was the initiator of these activities. Still, she blamed herself for not reporting what was happening to her mother or grandmother. And she was inclined to believe that she must have derived various sorts of pleasure and satisfaction from these events in addition to the distress they caused her. Over time, Mrs. A became more willing to acknowledge some validity to the reading of what had occurred as "childhood sexual abuse" and to accept that, in certain respects and to some degree, she may have been a "victim" and not merely a guilty agent. This greater flexibility of interpretation constituted therapeutic progress in my view.

VII. Imaginary or Symbolic?

Whereas some colleagues (illusioning) tend to take seriously the patient's phantasies (e.g., that he contains a helpless child, or suffers from a fragmentation-prone or defective self, or has multiple selves, or that she suffers from environmental illness, or was abused by her father and not just by her uncle in the absence of any memories or supporting evidence of the fact, or was abducted by aliens) others (disillusioning) seek not to confirm, reify or work within such literalized metaphors, phantasies or belief systems, but rather to deliteralize or deconstruct and promote the patient's disillusionment with and disidentification from them.[9]   How easily in psychoanalytic work, without realizing it, we regress from an iconoclastic into an idolatrous, reifying or literalizing technique and from productively triangulated work on the level of the Symbolic to Imaginary dyadic enmeshment and identification.

Clinical Example:

It took a number of years of analytic work for Mr. B to face the castration anxiety beneath his defensive phallic narcissism and, subsequently, the separation anxiety and dependency longings beneath that. It became clear that B felt himself to have been seriously deprived in childhood and, as a result, to be deficient, defective and "lacking" in important respects. In addition, he was enraged and resentful over his fate and envious of those he viewed as intact. In addition to being empty of goodness, he felt himself to be full of badness. By focusing on both his early deprivation and the pent-up rage arising from it, the analysis had been reinforcing both these self-images and, as a result, had been

threatening to become interminable. By unintentionally strengthening B's fixation upon a self-image as deprived and enraged, the analysis intensified his dependence upon the analyst as an idealized object who was felt to possess what he lacked and the capacity to fill in the emptiness and ward off the evil he felt he contained. All of this intensified his envy and anger, which only made B feel worse about himself and more dependent on the analyst, not least as a kind of protector in the face of the paranoid anxieties resulting from his projection of his envy and rage. B's thinly disguised anger toward the analyst, displaced onto older men in conscious reveries on the way to the analyst's office, was understandable in this light, however much it also reflected simple transference of the castrating and depriving parental imagos. Through emotional induction or projective identification B had induced in the analyst his need to suppress his anger. The analyst's eventual recognition of this enabled him to resolve his induced countertransference resistance to expressing his anger toward B in sublimated and controlled ways that assisted the patient to become more accepting of his own split-off aggression.

Although B's self-image as bad, helpless and lacking was grounded in his early experience of an overburdened and depressed mother and of a father who was belittling and both emotionally and physically absent, rather than constituting a simple deficit in self structure resulting from environmental failure, on further analysis it was revealed as an outcome of retroflection, B's turning against himself of the rage engendered by his early experience. One reason B continued to disparage and sabotage himself was that to move toward letting go of these negative and outmoded images (i.e., to stop tormenting himself) aroused intense conscious guilt feelings mixed with a range of separation anxieties. His masochism or self-torment functioned as a defense against conscious guilt. Part of this guilt seemed to be in reaction to his destructive rage and envy, while another part took the form of survival guilt: to cease viewing himself as dysfunctional and unhappy seemed tantamount to abandoning his siblings. It also threatened him with the eventual termination of his analysis and with finally having to face the fact that he would never receive what he imagined he had been deprived of, even from his surrogate father, the analyst. What had on the surface appeared as an ego defect reflecting early selfobject failure turned out to be the ongoing product of self-destructive processes

designed to protect B against a mixture of feelings of guilt and separation anxiety that he was initially unable to bear (Safan-Gerard, 1998). 10

Even otherwise iconoclastic therapists are sometimes inclined to stop analyzing when they feel they have encountered "rock bottom." For Freud (1937), such bedrock was constituted by castration anxiety in the male and penis envy in the female. Few analysts today are inclined to regard such phenemena as unsusceptible to further analysis. Today we are more likely to make this mistake when, having analyzed all the defensive self-images, we feel we have bottomed out, as it were, in an abyss of psychotic emptiness or confusion: a primordial deficiency in the patient's self-structure. This is where our courage as analysts (as distinct from therapists of other types) is put to the test. If we can persist with our iconoclastic or deconstructive method, this final myth of primordial chaos and deficiency may itself be exposed as yet another fiction of the "ego" serving a range of defensive functions, as in the case of B for whom such self-annihilation appeared to protect him from unbearable conscious guilt.11

VIII. Theory or Ideology?

But it is not just our patients who fall into the type of literalization I have been describing, but psychoanalytic theorists and practitioners as well (Carveth, 1984). Regrettably, the history of psychoanalysis -- like human history in general -- is, to a considerable degree, a history of reification, ideology and idolatry. One of the benefits of the state of paradigm dispute that has prevailed in psychoanalysis for the past several decades is to make it more difficult (but by no means impossible) for psychoanalysts to continue to hold their theories in an ideological or idolatrous fashion. Paradigm dispute encourages comparative psychoanalysis and facilitates the development of multi-paradigm training programmes and the emergence of an ever larger cohort of practitioners who refuse to identify exclusively with any one of the currently available models and who insist upon familiarizing themselves with and utilizing elements of each in a flexible and non-idolatrous fashion, recognizing the concepts composing them as metaphors more or less useful in particular clinical contexts.

Although he gave it the subtitle "A Synthesis For Clinical Work," Pine's (1990) *Drive, Ego, Object and Self* offerred no real synthesis but only a pragmatic (and politically useful) clinical pluralism. Several years later, however, Pine (1995) wrote a paper with the title "One Psychoanalysis

Composed of Many." It seems that Pine himself had become dissatisfied with the sort of pluralism that foregoes attempts at critical integration in favour of the sort of pseudo-tolerance that accepts the existence of multiple perspectives, as long as they each retain their integrity and are in significant ways kept separate from one another (like the meat and dairy products in orthodox Judaism).

Such non-integrative and uncritical pluralism recognizes the existence and affirms the legitimacy of Freudian, Kleinian, Kohutian and other perspectives and even suggests that while one patient might best be understood from within one such framework, another might better be approached from another. But it does not encourage the sort of critical thinking, comparing and contrasting, and winnowing that would lead one to attempt to separate the wheat from the chaff in each perspective, to eliminate the chaff and collect the wheat, and to practise from the standpoint of the resulting open and evolving synthesis.

Attempting to think and to practice in the latter way myself, I find I am sometimes taken to task for borrowing from, overlapping and not clearly fitting into any one of the current theoretical/clinical pigeonholes that characterize our field. There appears to be a latent norm operating to the effect that one should not mention the paranoid-schizoid position (let alone PS) unless one is a Kleinian; one should not discuss "lack," the phallus, or the Imaginary, the Symbolic and the Real, unless one is a Lacanian; nor mention the selfobject transferences unless one is a Kohutian. Such an attitude is, of course, essentially unintelligent, but it does offer a certain satisfaction to minds that need the security of working within one or more coherent systems, or that operate more in terms of flags, emblems and badges of identity than of critical reason.

Recently, after several years of discussion in the Curriculum Committee of the Toronto Institute of Psychoanalysis regarding tensions and problems that had emerged in several recent classes of candidates, it finally became evident that these difficulties were intensified by certain types of instructors and instruction and alleviated by others. In a recent paper reporting her research in this regard, Levene (1996), who had herself been a candidate in one of the classes concerned, writes: "In summary, the results suggest that although the level of class conflict may have multiple determinants, the nature of the teaching model employed -- that is, a discrete metapsychological model (either classical, ego psychology, object relations, or self psychology, but not more than one preferred perspective) versus a comparative model (a model that suggests there are multiple ways to

understand clinical phenomena) -- may influence the level of class conflict" (p. 338).

I believe the difference between what Levene calls the comparative and discrete pedagogical approaches echoes the distinction between iconoclastic (deconstructionist) and non-iconoclastic (constructionist) psychoanalytic techniques. Whereas in the latter, usually without fully realizing it, the analyst joins the patient in the creation and reification of various constructions of his or her past and present identity -- as opposed to assisting the patient in the discovery and deconstruction of such constructions and in disidentification from them -- so, in the teaching situation, the educator may either seek to communicate the validity of various constructions regarded as the truth (the discrete approach), or seek to convey such constructions as metaphors, more or less useful for various purposes and in various contexts, thus preserving a degree of critical distance and disidentification from them (the comparative approach). In Kleinian terms, this is the distinction between analytic or pedagogical work on the level of PS or D, between interpretations or theories operating on the level of "symbolic equation" or "symbolic representation" (Segal 1957), and between the undigested and undigestable "beta" elements resulting from the failure of "alpha function" and the creative insights opened up through its successful application (Bion 1962).

If the iconoclastic view of psychopathology as "dead," "frozen," literalized or concretized metaphor and opposition is correct and, hence, the (ultimate) goal of treatment is deliteralization, dereification or deconstruction, then it is ironic that in so many psychoanalytic training settings teaching is not infrequently carried on in a non-iconoclastic manner that reflects the very psychopathology, the literalization or concretization of metaphorical perspectives (i.e., the loss of alpha function), that we seek to cure. There is even a sense in which non-iconoclastic teaching practices reflect oedipal psychopathology: for in losing any sense of the gap, space or boundary between our theoretical models and the domains they seek to map, there is a loss or denial of triangulation. Instead of the triad composed of the model, the domain, and the "contact/barrier" (Bion, 1962) linking and separating the two, there is a regression from the oedipal triangle and both the differentiation and integration characteristic of the Symbolic into both the splitting and the identification, the defusion and confusion, characteristic of the preoedipal dyad and of the Imaginary.

It is for this reason that, in my view, any insistence that proper psychoanalytic technique be purely iconoclastic or disillusioning itself

reflects a concretized association and, hence, a regression from a higher-level form of iconoclasm. In the latter there is recognition of both constructionist and deconstructionist elements in the analytic process. Whereas Grotstein (1996) wishes to associate the former with psychotherapy and the latter with psychoanalysis -- even while admitting that psychoanalysis inevitably contains psychotherapeutic elements -- I am more inclined to argue that in both psychoanalysis and any form of psychotherapy devoted to insight, constructionist elements necessarily coexist with and even establish the necessary conditions (as working or therapeutic alliance, holding environment, conditions of safety and trust, empathic and affective attunement, and so on) under which the deconstructionist element of the therapeutic process may occur. But this is in no way to deny that there are forms of psychotherapy, some of which even insist upon misrepresenting themselves as psychoanalytic, in which constructionist, illusioning and identifying elements have virtually displaced deconstruction, disillusion and disidentification altogether.

If, through analytic deconstruction and disidentification, we succeed in becoming relatively disillusioned and, eventually, disillusioned even with our disillusionment, we may reach a state in which we no longer believe (in the idolatrous sense) in anything -- and certainly not in nothing. It seems that far from needing to possess a firm (specular) ego in order to function in this world, we function far better as subjects liberated from such "possession." If we interpret Freud's and Hartmann's structural ego as the hypothetical apparatus mediating, like the brain itself, the functioning of the subject, then we may say that this (structural) ego functions far better when freed from interference by the "self" (specular ego, self-image or self-representation). For such acts as shooting the arrow, arranging the flowers, falling asleep, getting an erection, having an orgasm, riding a bicycle, freely associating, listening with freely hovering attention (Freud) or without memory or desire (Bion), etc., are quite distinct from, and even incompatible with, the act of watching ourselves do or attempt to do these things (Herrigel, 1953; Epstein, 1995) -- however essential such watching may be in first acquiring certain skills, in disrupting unwanted habits and, more generally, in self-monitoring, self-correcting and self-controlling activity.

In an important sense, it is not that our most disturbed patients, those in the psychotic and borderline spectrum, have insufficient ego strength or an insufficiently cohesive self. In a certain sense, they suffer from an ego (self) that is far too strong and cohesive (albeit in the rigidity of its fusions and splits) and that, like the idol that it is, exercises a kind of totalitarian control

over their lives. Of course, in another sense, they have insufficient (structural) ego strength to be able to deconstruct and disidentify from the (specular or representational) ego or to enjoy a sufficient sense of the gap between themselves as egos and themselves as subjects to at least be able, on occasion, to laugh at themselves.

IX. A Higher Rationality: Containment and Strategic Joining with Inner Reserve

While the model of therapy as deconstruction, disillusion and insight through interpretation works well with neurotics organized predominantly on the level of the so-called depressive (Klein, 1959) or historical (Ogden, 1986) position (D), patients suffering from preverbal or preoedipal fixations and organized predominantly on the paranoid-schizoid level (PS) are highly resistant to it. While it may be the case that such patients require a kind of "ego-building" to facilitate a developmental shift from PS->D, thereby promoting the emergence of a subject capable of self-reflection and thus rendering them accessible to ordinary analysis, it is by no means clear that such preparatory work must take the form of a constructionist, illusioning or identifying approach. An alternative to both ordinary interpretive work and ego (self) enhancement through inspiration and identification is ego-strengthening through the resolution of intractable resistances that renders analytic progress through insight, reality-testing, mastery and mourning possible.

In answer to the question posed in the title of this paper, I believe there is indeed a future in disillusion. Truth therapy need not always be abandoned in favour of support, inspiration and identification in work with more primitive personalities. What is essential to recognize is that such patients are both terrified and (unconsciously) enraged. They have far too much anxiety to be able very easily to call themselves into question, and far too much basic mistrust (and paranoid anxiety due to projected aggression) to be able to cooperate with the therapist in a working alliance of the sort that generally emerges fairly readily with neurotics. Although they do not free associate or bring interpretable material in the usual ways, through their very resistances they convey to us their own maddening emotional life. By means of emotional induction or projective identification they evoke in us feeling-states of a highly distressing sort that are difficult for us to tolerate.

I employ the term "tolerate" here in order to distinguish positive Bionian containment, in which the analyst "holds" the patient's "poison" in order to "detoxify" or "metabolize" it through "alpha function" and return it in

digestible discursive or nondiscursive symbolic forms, from the negative containment in which patients dump their madness (undigested or undigestible "beta elements") into us, giving them relief by driving us crazy, or in which we contain negatively, in the sense of destroying and then evacuating or re-projecting what has been projected into us. While we should certainly not be containers in the sense of overly identifying with the feelings and roles patients pressure us to feel and even enact, we do need to tolerate such induced feelings -- i.e, contain them in the positive Bionian sense.

To do this, I believe it is essential that we attempt to distinguish the *subjective* countertransference arising from our personal issues and conflicts from the *objective* countertransference representing the feelings of our analysands that have been evoked or induced in us (Spotnitz, 1969, ch. 9) as they attempt to make us suffer what they suffer -- positively, out of a desire to communicate and, negatively, out of sadism. If we can recognize this, we will not take what is happening too personally and, as a result, we may be able to tolerate the induced feelings, to feel compassion for our patients (we know how they feel!), to hold and manage the therapeutic frame, to appreciate and not merely oppose the resistances, even to join them on occasion, and to interpret in a way that our analysands can hear as truthful and begin to use to get a bit outside of and begin to disidentify from their enclosed or foreclosed psychic realities. In these ways, we may be able to assist such patients to tolerate rather than evacuate the psychic pain their pathology has served to evade, to put it into discursive or nondiscusive symbolic forms, 12 to learn to think about it and to begin to learn from experience.

As a part of such containment, it may be necessary at times for the analyst to strategically refrain from calling the patient's psychic reality into question, while maintaining an inner reserve and a determination to confront, question, clarify and interpret it once a therapeutic alliance, sufficient observing ego and an object as distinct from a narcissistic transference (i.e., a whole object vs. a part-object and part-self transference) have developed. Such toleration by the analyst of the analysand's irrationality is not necessarily to surrender the rational goals of analysis, but merely to adhere to a "higher rationality" capable of distinguishing a battle from the war.

Can rationality and self-reflection be achieved by non-rational and non-reflective means? How else could they conceivably be achieved? How are rationality and the capacity for self-reflection developed in children? Do

they not at least to some extent come to accept the reality principle and to call themselves into question out of love for us? Is it not our containment and holding, in addition to our instruction, boundary-setting and boundary-maintenance, that enable them to do this? Surely Winnicott (1989) is correct when he emphasizes the mother's responsibility "to give the baby the illusion without which disillusionment makes no sense" (p. 429) and to view analysis as a process in which, *for a time*, the analyst, like the parents, refrains from asking whether the object is inner or outer, invented or found, constructed or discovered, an act of forbearance (but not of forgetting or blurring these distinctions) that assists the analysand to undergo a crucial *transition* from relations with subjective objects to relations with objects objectively perceived.

Unfortunately, these questions are no longer being struggled with by those who have long abandoned Freud's enlightenment ideals in favour of some pragmatic version of the cure through suggestion, conversion and transference, the therapeutic or gnostic religions of illusion and identification, from which he always sought to distinguish an authentically emancipatory and disillusionist psychoanalysis.

Notes

Journal of the American Academy of Psychoanalysis 27, 2 (1999): 325-358. This is a revised version of a paper presented at the annual meetings of the American Academy of Psychoanalysis, Toronto, May 30, 1998 and published under the title "Is There a Future in Disillusion? Insight Psychotherapy in the New Millennium" in *JMKOR: Journal of Melanie Klein & Object Relations* 16, 3 (1998): 555-587.

1. In this paper, as in other of my writings (Carveth, 1984; 1987; 1999), I employ the term deconstruction in a very loose sense to refer to a critical method that seeks in regard to any text, in this case that jointly produced by analysand and analyst, to expose its latent or background assumptions, the various identities and oppositions out of which it is composed, its hidden contradictions, the disguised return of the repressed within it, and so on. In other words, although cognizant of the work of Derrida (1976), my use of deconstruction is sufficiently general as to make it virtually synonymous with both critical reason in general and the psychoanalytic method in particular.

2. In referring to drive theory as outmoded I mean in its literalistic form in which the *triebe* are defined by aim, object, pressure and source, the latter being held to be a *somatic* organ or zone (Freud, 1915). In a broader, more psychological and less reductively biologistic form, as a theory of libidinal and aggressive *motives* and of oral, anal, phallic and oedipal *meanings* (freed from their alleged somatic sources, without of course denying the grounding of mind in brain) it remains significant (see Brenner, 1982, chapter 2).

3. The term "invalidation" has come to have an entirely negative connotation in therapeutic circles, causing us to forget how soothing, reassuring and liberating it was when, as children, our significant others did us the favour of invalidating our nightmare fears. Such invalidation is, I feel, an essential element of therapeutic work, especially with psychotic and near-psychotic patients. I hope one day to write a paper entitled "On Optimal Invalidation in the Therapeutic Process" to complement Bacal's (1985) emphasis upon "optimal responsiveness." Of course, Bacal might respond that sometimes the optimal response is invalidation! Although such an admission is gratifying up to a point, it at the same time arouses skepticism regarding a theory so infinitely expandable as to be able to say this.

4. The distinction between *live* and *dead* metaphor respectively overlaps to some degree Bion's (1962) distinction between *alpha* and *beta* elements (the former have undergone "alpha-betization"), which itself resembles Segal's (1957) distinction between *symbolic representation* and *symbolic equation*, which in its turn parallels Klein's (1946) distinction between the *depressive* and *paranoid-schizoid* positions. Whereas on the level of the depressive position the distinction between the metaphorical and the literal is maintained and each form of conceptualization and communication is employed in its proper domain, on the paranoid-schizoid level the distinction is blurred or lost altogether and the subject treats the metaphorical as the literal and vice versa.

5. A drawback of the metaphors "dead" and "live" in this context is the false and unintended association of "dead" metaphor with states of relative emotional "deadness" and "live" metaphor with more "lively" states. In reality, "dead" or concretized metaphor, like paranoid-schizoid processes in general, can lead to states of great emotional intensity, while "live" metaphor, like depressive position phenomena in general, may be productive of more muted or modulated, even at times "deadened," emotional states. For example, if (as in the "dead" metaphor) life really is a

jungle, then daily existence becomes a very intense matter of life or death.

6. "**Iconoclasm** n. breaking of images (lit. or fig. ...); **iconoclast** n. breaker of images, esp. one who took part in movement in 8th-9th c. against use of images in religious worship in churches of the East, or Puritan of 16th-17th c.; (fig.) one who attacks cherished beliefs . . ." (*Concise Oxford Dictionary*, Sykes, 1982, p. 494).

7. In saying the *subject* may in these circumstances begin to make an appearance, I do not mean to suggest that anything like a knowable "true self" comes into view. In the iconoclastic perspective elaborated here, any such notion would simply be an occasion for more analytic deconstruction and disidentification. But if such work should prove productive then, freed from domination by all "self-knowledge" -- by all the idols, icons and imaginings of the ego -- the resurrected *subject* could, like Lazarus, resume its *going-on-being*.

8. Such *believing* should be distinguished from the tactical *joining* of the patient's phantasy as a short-run means to the end of disillusionment in circumstances where the patient has not yet developed or has temporarily lost sufficient observing ego to work on more rational levels.

9. Except in the case of the analyst's self-conscious decision to employ a tactic of joining or entering into the patient's phantasy-system as a means to the end of helping him out of it (Lindner, 1950).

10. This is not the place to go into a discussion of Ury's (1998) position that guilt is a primitive and destructive manifestation of the archaic superego to be distinguished from the operations of conscience which involve secondary thought (ego) processes. My own position is that the operations of mature conscience do in fact result in conscious guilt. Furthermore, people who find such conscious guilt unbearable (because they are caught in paranoid-schizoid splitting wherein to cease to be all-good is necessarily to be all-bad) defend against it by automatically resorting to self-destructive, projective and other defensive processes. Freud described such unconscious self-destruction as the unconscious need for punishment and he equated this with unconscious guilt. I propose that we abandon the concept of unconscious guilt altogether and reserve the term guilt for the conscious experience of a bad conscience against which unconscious self-destructive and other processes frequently defend, as Safan-Girard (1998) has recently illustrated.

11. It is notable that Lacan himself appears to have been captured by an Imaginary reification of the phantasy of "lack" that prevented him from recognizing that *manque-a-etre* is no more to be privileged than its binary opposite, *plenitude*,or any other signifier in the Symbolic order.

12. Following Langer (1951), I do not identify language exclusively with its verbal or discursive forms or privilege speech over the languages of art, music, dance, mime, liturgy and other non-discursive symbolic forms. I believe it has been a mistake to identify psychoanalysis as "the talking cure" exclusively. What is essential is not that patients put everything into words, but that they put everything into symbolic forms (Carveth, 1999b).

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