

**HANS W. LOEWALD MEMORIAL ADDRESS**

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**Ferrum, Ignis, and Medicina:**

**Return to the Crucible**

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Anyone who visits a meeting of the American Psychoanalytic Association these days will be astonished at the breadth and vigor of its debates. We see intellectual ferment everywhere. But is that all we see? Is it just a variety of arguments--conflict vs. deficit, narrative vs. fact, etc.? Or is there an edifying story here--a story about a journey into our current issues and on to the goal of psychoanalysis in its second century?

Well, yes of course, there's a story ... and another story ... and, unfortunately, another story, each crafted to celebrate somebody's favorite outcome. In reality, there is no privileged history of anything. So the short answer to my last question is no. There is no road that led here. Psychoanalysis concerned itself with modern issues very early and with original issues again very lately. It has straggled into view over a wide field and it is still straggling. It wasn't a disciplined march. There is no triumphal entry. Sorry.

Now, that's not a very promising beginning; I should start over and be less circumspect. This time I'll weave together highly personal impressions and generalizations and indulge in grand and free confabulation. That's not so reprehensible, really. The art historian E. H. Gombrich tells us that if we want to achieve a likeness we have to begin by hacking out a rough image and then comparing it to reality. Only by match and mismatch do we reach a faithful representation. So we can't lose, you and I: I will tell you my fable and you will spot my mistakes and we will end up seeing things more clearly.

In order to help you take your position I'll forewarn you of my conclusion. My moral is that today's arguments are efforts to pull secrets of human nature out of the very fabric of the treatment situation, treatment here regarded not merely as an instrument of discovery but as an isolated wet specimen to be examined.

How can mere arguments reveal facts of nature? Well, consider this: analytic treatment comes about, in the first place, because of the analyst's attitudes. There is nothing else to make treatment happen. If treatment does something unusual to people, then we can learn about people by picking out the attitudes that make treatment happen, and especially by watching how the attitudes sit together and squirm together to get the job done. And where better to observe treatment attitudes sitting and squirming than in our collective controversy over the course of our discipline's history. With psychoanalysis, the history of ideas is not a background study; analytic history literally assembles the tools of treatment, and it is history that paints subtle meaning onto our stock concepts. And history is even more important for our purpose this afternoon: When over the years analysts try, this way and that, to match their attitudes to the task of treatment, they are doing nothing less than palpating the human condition.

Intending no disrespect to other schools, I'll talk only of Anglo-American, Freudian analysis. And I'll pay no attention to the influence of momentary fashions, philosophical and otherwise, because I am discussing not ideas in general, but how attitudes are designed to serve the needs of an established treatment.

Now, it will not escape your notice that when I ask how ideas serve the needs of treatment I am presuming that there is a psychoanalytic treatment out there waiting to be

served--I am supposing that psychoanalytic treatment is an enduring structure that can be lit up by turning on various ideas and attitudes, and, further, that we are so familiar with this treatment that we can hold up its physical likeness in one hand and its associated ideas in the other and tell which treatment postures go along with which ideas.

I am suggesting, you see, that Freud did not design a treatment; he discovered one. First he stumbled on the treasure while following his personal aims. Then he modified the personal motives and made them into a behavioral map by which others could find the treatment directly. The attitudes he recommended, having been reenacted over the years, in essence if not in detail, make Freud's discovery available in every consulting room where it can be repeatedly identified and empirically examined. We can spot psychoanalysis by its gross appearance, especially by the attitudes that produce it. I will try to catch the spirit of those attitudes by imagining their root form at the time of discovery and then noting what sort of tinkering was necessary to turn them into reliable producers of the treatment Freud had stumbled on. I want to trace Freud's attitudes of discovery as they are transformed into attitudes of technique. Then I will speculate on their subsequent fate.

If I am wrong in my assumption--if treatment is just the application to patients of whatever analytic theory happens to be knocking around at the moment--then my method is pointless. So if you doubt that psychoanalytic treatment has an enduring life and shape of its own, please suspend disbelief this afternoon, because I need two heroes for my story of how we got here. One hero is the collectivity of you and your predecessors--no problem there. But the other hero is psychoanalytic treatment itself, and to conjure that one up I must, as I go along, refer to its identifying physiognomy. And let me make it clear that when I say physiognomy I mean just that--the grossly observable features of the treatment situation. Please be prepared for a certain bluntness of language. Remember, it's attitudes that we're trying to get hold of--attitudes that turn treatment on. And to portray attitudes we must paint with a broad brush and use bold colors, because that's how attitudes are identified--certainly not by careful, technical phrases. Indeed, when practitioners insist on putting their attitudes into technical terms they are usually hiding elements of manipulateness, and that is another, very useful attitude: that of innocent attitudelessness.

Come with me now back to 1895, and look at the experience reported in *Studies on Hysteria*. Everyone knows that psychoanalysis grew out of the search for memories, and that Freud's ambition was to make great discoveries. If the historical path to treatment is any clue to its nature, then curiosity must certainly be at its heart. That needs no argument, so I shall proceed to the next attitude on my list.

So vivid is the image of Freud as Discoverer that we sometimes forget that a proud man here is a proud man there. As a self-proclaimed physician, Freud had pride in his practice and in his person. He hated to have his bluff called. He disliked having patients show him he was wrong when he told them they would go into a trance. He did not want his authority to be dependent on his patient's response (Freud 1917, p. 45 1). No wonder he welcomed Breuer's cathartic treatment, "a practice," he tells us, "which combined an

automatic mode of operation with the satisfaction of scientific curiosity" (Freud 1914, p. 9). Breuer's treatment was automatic in that it was guaranteed by the patient's normal digestion of memories.

In fact, the new treatment followed the patient's own inclination so reliably that hypnosis proved superfluous. And going a step further, Freud discovered that he always got what he was after if he obeyed hints from patients like Frau Emmy v. N. (1895, p. 63), who wanted him to stop bird-dogging his objectives and listen to hers. Once again following the patient's wishes, Freud made inclinations such as Frau Emmy's into his own fundamental rule.

This new procedure put Freud in an entirely different position: No more praying for a trance. No more begging for simple memories. No more pleading for clues to symptoms. If the therapist has any question at all, it's a mild wondering about the mood of the moment. Now almost anything the patient says will satisfy Freud. Since he no longer hungers for atoms of significance, and since he is expecting only a vague network of thoughts with only a remote reference to his interests, he can't miss: his professional pride and intellectual confidence are no longer at risk. My point is that psychoanalysis, in addition to being a method of discovery, was Freud's way of immunizing his treatment authority. He writes: "It is of course of great importance for the progress of the analysis that one should always turn out to be in the right vis-a-vis the patient, otherwise one would always be dependent on what he chose to tell one . . ." (1895, p. 281).

The trick was to endorse the patient's wishes. That's what made the treatment reliable. When he had formerly asked for a particular service, such as falling into a trance or reporting a memory, Freud was at the mercy of his patient, who might or might not grant his wish. The new treatment that Freud discovered required, instead of a particular service, a whole human relationship, and that is something that people have a hard time withholding. Freud could count on it--provided he himself could muster a special interest.

Freud's unguarded description of this special interest reveals its raw nature, which later will be obscured by technical formulas. Freud's fresh, first impression is that the analyst's attitude is quite different from physicianly attention. "I cannot imagine bringing myself to delve 'into the physical mechanisms of a hysteria in anyone who struck me as low-minded and repellent, and who, on closer acquaintance, would not be capable of arousing human sympathy; whereas I can keep the treatment of a diabetic or rheumatic patient apart from personal approval of this kind" (1895, p. 265). What sort of attention is this? We can suppose that it involves a human endorsement and a personal (rather than just an ethical) wish to help. Carried forward, the analyst's human commitment and his curative intent remain for us today the most familiar--and certainly the proudest--of his treatment attitudes. And perhaps I would be wise to end my inventory of analytic attitudes right here, having mentioned curiosity, respectful sympathy, and a desire to help.

But I'll be reckless and ask, What did Freud's interest evoke in the patient? Although Freud later publicly pleaded that an analyst asks no more than the privilege of a gynecologist, he knew otherwise and said as much upon his first encounter with

psychoanalysis. He recognized that he was doing something forbidden to physicians; he was deliberately courting a personal, affective intimacy. The patients "put themselves in the doctor's hands and place their confidence in him--a step which in other situations is only taken voluntarily and never at the doctor's request" (1895, p. 266).

And Freud was honest enough to recognize that the intimacy he wanted from his patient might be the sort of personal surrender that counts on a love relationship and must honorably be reciprocated with something more than cure: "in not a few cases, especially with women and where it is a question of elucidating erotic trains of thought, the patient's co-operation becomes a personal sacrifice, which must be compensated for by some substitute for love. The trouble taken by the physician and his friendliness have to suffice for such a substitute" (1895, p.301). In this first glimpse of the situation, Freud remarks that, quite apart from individual transference, a patient will sometimes experience a dread of becoming "too much accustomed to the physician personally, of losing her independence in relation to him, and even of perhaps becoming sexually dependent on him.... The determinants [of this situation] are less individual [than transferences]. *The cause of this obstacle lies in the special solicitude inherent in treatment*, (1895, p. 302; emphasis added).

Let us be as bold as Freud. His effort to make great discoveries, and also conduct a confident cure, had unexpectedly put in his hands a peculiar power--the power of a psychological seduction. I shouldn't have to--but I've learned that I had better--add quickly that this seduction is unique, careful, modulated, responsible, therapeutically intended, unselfish, and nonabusive. I have no wish to be provocative. I know that many of you find the word *seduction* intolerable--and for very good reason. But since some elements of treatment exist for the very purpose of cushioning that discomfort, we will understand less about treatment if we hide the discomfort in a euphemism.

By seduction I mean an arrangement whereby the patient is led to expect love while the analyst, in Freud's words, plans to provide a substitute for it. Admittedly the love-substitute is something very special, with secrets we have yet to fathom, but it is not the love the patient is imagining. At that early moment in analytic history one of the conspicuous features of treatment was put in place, namely, the analyst's special interest, his constant, exclusive, selfless attentiveness--an attentiveness which I believe (though this is only implied by Freud) will inevitably spark a flickering apparition of the analyst's deep and lasting attachment to the patient. That illusion may be viewed skeptically, or rationalized out of awareness, or fended off, or kept in the background, or wondered about or feared, but it is always a nidus of uncertainty at the center of treatment, placed there deliberately by the psychoanalyst.

That's not the whole story, of course. The patient also rides the analyst's attention back into himself, where he finds a new respect for--and hopefulness in--the rich potential of his own distress. Even if you can't abide my bad language--my talking about illusion and seduction when every well-bred tongue knows how to pronounce "transference" and "regression"--I'm sure you will agree with me that Freud discovered a unique attitude, let us say, of expectant appreciation (an attitude that possesses perfectly extraordinary

eliciting power), and you will agree that this attitude is a hallmark of psychoanalytic treatment.

And perhaps you will agree also that part of what makes the analyst's personal interest so unique is that it is allowed to remain ambiguous for years, while any straightforward declaration designed to clear up the ambiguity is deliberately avoided. Though he may question the patient's beliefs, the analyst never says what the extent and limits of his caring are. (I need not cite Freud's advice to neither encourage nor discourage transference love.)

Uncertainty about the analyst's attachment is a source of discomfort. But it is not just that; it is also a tactical problem inasmuch as the need for the patient's attachment gives evidence of the analyst's continued obligation to bargain. Freud learned soon enough that, left to themselves, patients would not aim at his target, and he was actually relieved to find, as he tells us, that "free association is not really free. The patient remains under the influence of the analytic situation" (1923, p. 40).

Thus, patients were still being subjected to suggestion, if not by Freud's words, then by his procedure. And, accordingly, Freud was still in the position of bargaining. For one thing, without hypnosis he would be the one who saw the hidden meanings, and he would have to persuade patients to believe what he saw (Freud 1904). But that was the least of his problems. The bigger problem was that, though he had coopted some of the patient's wishes to his own ends, in fact the only wish he ever really endorsed was the wish to remember; other wishes were always something to be tamed. And taming remained a problem. Patients could refuse to produce evidence. They could stop talking. They could demand an entirely different relationship. The method was not as dependably automatic as it had seemed.

Freud did not flinch from the larger implication. By 1912 he knew he was no longer in the modest business of retrieving memories. He was back in the persuading business. Even just to conduct the treatment he had to persuade patients to live differently, more courageously, more realistically, etc. (Freud 1912; Falzeder 1994). His wanting that from patients made him dependent on them again. Freud saw the trap more clearly than did Jung or Ferenczi, and he resolved to extricate himself. He would use his influence, but in a way that did not entangle him in compromises. Having already learned not to ask, he would now try to not even want any particular information. And he resolved to stop entreating patients to get well; he would make them come to him and solicit him. He wrote to Jung: "you still engage yourselves, give away a good deal of yourselves in order to demand a similar response.... [O]ne should rather remain unapproachable, and insist upon receiving" (Fatzeder 1994, p. 314). But here's the problem: If the procedure has any point to it, the analyst has to go after *something*. If he is diffident about causes and he's not evangelical about health, what will he pursue?

Freud very early found an attitude that solved this practical dilemma, and successive generations have reproduced the handy attitude. How? By thinking in terms of resistance, which was Freud's behavioral map through this minefield.

The resistance was the something that Freud could be passionate about, struggle with, go after, and still remain a neutral conduit for what the patient ultimately wants and would naturally produce (were it not for the resistance). It was not just a rhetorical trick, provided there was something that both he and the patient could fight against. Freud thought there was such a thing: the enemy was a motivated ignorance of inner reality that limited the patient's autonomy. By fighting against the ignorance Freud was freeing the patient's decision making. In that way Freud could still count on the force of the patient's own wishes to serve the analyst's purpose. The analyst could press his own case without entreating the patient and without manipulating the patient because the patient's ultimate response was *guaranteed*, theoretically, by a third presence--objective truth, truth undistorted by the analyst's and patient's preconceptions and wishful thinking (Freud 1914). Objective truth serves two purposes: In the first place, it is a gratifyingly clear goal for a distressingly undefined partnership. In the second place, truth is a monitor that allows the analyst to exert influence without compromising his liberating purpose. Let me say just a few words about each of these two services.

First, let us consider why it is so important to have a clear goal. Floating above both parties--usually silently is the unanswerable question of what exactly the analyst's investment is in his patient. Any therapist will be less uneasy if he can point away from that uncertainty to a straightforwardly mutual task of investigation that goes on regardless of the relationship. In other words, a personal ambiguity is balanced by an objective work relationship. And that balance is fostered by the idea that whatever is or isn't real in the relationship, it is all for the purpose of bringing objective truth into sight. Thus, an attitude oriented to objective reality takes some of the vertigo out of the relationship.

Now, about the second way that objective reality serves the analyst--how does it lessen mutual dependency? Freud worked his way out of mutual dependency by balancing his affectionate interest, which led to personal entanglement, against an opposite, disentangling attitude--an attitude that can be fairly characterized as socially adversarial. I say, socially adversarial. Obviously Freud was not an adversary of his patient's welfare. That qualifier understood, I will now speak simply of adversarialness. Many have commented on Freud's bellicose treatment images. We are all familiar with his famous martial metaphors. From first to last Freud was in a struggle. If it's a matter of Freud's own writings, I hardly need to argue my case for adversarialness, and in fact, that very word has often been used in personal criticism. But my purpose here is to emphasize the universal service that this adversarial attitude renders to the treatment that Freud discovered.

Let us look back at the original adversarial attitude that led Freud to the treatment. Freud, as I have suggested, was impatient for great discoveries, and, as Schafer has noted, that made him an adversary to patients who barred the way. But let us ask: did Freud become less adversarial when he stopped fishing for memories and started nourishing a whole relationship with his patients? On the contrary, the adversarial attitude became even more essential at that point. For now it was not just the Conquistador who was fighting; it was also the adamant therapist. The researcher's impatience was being trimmed to a different

service, a different ruthlessness--one that would sustain the newly discovered treatment. After all, free association was a way of paralyzing the patient's ' will, and that's a fairly adversarial thing to do. But it is just one example of a general attitude. Through each revision of treatment, Freud was reconfirming and deepening his first lesson, namely that wanting something from a patient defeats the purpose. As I have noted, Freud found that he lost leverage when he engaged patients too wholeheartedly. They would play out their neurosis on the instrument of his therapeutic desire. He had to retain autonomy not just to make discoveries but to keep himself free of the patient's manipulation, and the patient free of his.

By 1912 Freud saw that an allegiance to objective truth would solve the problem: addressing himself to objective truth, he could preserve his independence even while he was involved with the patient's wishes. The patient was wrestling with a transference figure, but Freud was wrestling with resistance to objective truth, and ultimately--I emphasize, ultimately--none of the patient's holds could succeed in making out of the search for truth a repetition of an unhappy old childhood routine. The patient finds that this, the most open intimacy of his life, paradoxically diverts him to objectivity.

And for his part Freud could make a demand on the patient without offering a piece of himself in exchange (without losing his skin, as he put it). He would offer die truth rather than his own love or approval. The injunction to confront objective truth gave the patient an endless task by which he could endeavor to win the analyst's favor. You know that patients will scan every treatment for a sign of what is wanted of them. What they find in that search is what I will call the demand structure of the treatment. If you don't offer one demand, the patient will perceive another. Freud provided a demand: Let up on your yearnings and aim for objective truth!

And that, in turn, would free the patient. The patient could please Freud only by seeking the truth. And the truth would then make the patient free, because he would be putting himself into a position where he could *choose*, instead of being compelled automatically. The rule of abstinence is simply a corollary of these considerations.

And so from 1912 to 1914 Freud recommended to us the cardinal concepts of transference, resistance, and objective truth so that we might put ourselves into this useful, semiadversarial frame of mind. We welcome what the patient is revealing, but we think he's revealing it in order to conceal something more important. Nothing is more characteristic of psychoanalysts than their inclination to *see through* everything. The adversarial attitude is so ingrained in analysts that it affects their collegial discourse. Just as a patient's cooperation is never innocent of resistance, so a reported treatment can't go well without a zealous observer suspecting an error of collusion. And, justified or not, the profession's response to Loewald and to Kohut was surely influenced by fear that they were diluting a fundamental, adversarial attitude.

I realize that none of you will recognize adversarialness as a feature of your treatment. You are more likely to see what I am pointing to if I ask you to reflect on the balance you keep between analytic credulity and analytic skepticism. Though analysts cannot miss

Freud's adversarialness, accompanied as it is by drums and trumpets, their own adversarialness is usually manifested quietly, as analytic flexibility. What I call adversarialness, and what Freud described in similar idiom, refers to the way the analyst sets his face against appeals by the patient, denies bids for validation and reassurance, sternly summons what is most reluctant, rebuffs advances to "buy" any picture of the patient or his fate, waves away comforting roles, and says to everything, in effect, "No; something else." Adversarialness deconstructs the patient's presentation and frees the analyst's imagination. It eyes appearances skeptically and keeps looking for a reality beyond. It shuffles dramas and story lines and deflates lessons and moralizing.

The significance of this last point can hardly be exaggerated. Ordinarily we see people as dramatic figures. Schafer is right: narrative is the way we understand human action. And where our imagination is least constrained, there we make up the simplest and most persuasive stories. We "know" public figures more crisply than we know our spouse. It's more obvious what to do about the national economy than how to deal with the kids. Until we are assaulted by complexity, until we are entangled by love and responsibility, we see a simple, old-fashioned melodrama of good and evil, and when we don't have to act we moralize fiercely.

So we can't help seeing patients that way or they us. Analysts, despite themselves, often view process this way. Once in a while they slip and hear themselves say that their patient is trying to get away with a wicked treatment perversion, or flagrantly abusing the process in some fashion. But then they recapture Freud's adversarial attitude, which says that what's seen is in any case just surface, and they sober up on the objective truth of the mind with its perfectly neutral psychodynamics. A mental mechanism may malfunction, but it can't misbehave. One frequently sees Freud personally alternating this way: his letters express his moralized dramas while his published theory tends to neutralize them.

Moralizing keeps drilling into treatment, as indeed it must, but it is constantly swept out. Of course the analyst must experience his own effort dramatically--no one perseveres in a tough project over years without some agonistic framework. So an official drama of treatment is available--but only one: the crusade against resistance. Yet fighting the resistance is probably the least confining, the least defining, drama that a therapist can act in, because resistance itself is so ill defined. (Compare, for example, the fight against a "false self," which is so much more dramatically specific.) Other than the single image of fighting resistance, no drama is finally accepted by the Freudian analyst. No sense of "what we're doing together" hardens into routine. No patient is finally pigeonholed. The adversarial attitude refuses them all.

The adversarial attitude and the hunt for objective truth--these characterize the whole of treatment. Every time an analyst sees an event as an instance of something larger, he is endorsing Freud's view of the mind as an object. Every time an analyst disengages himself from an ordinary social response, he is utilizing Freud's adversarialness to social offerings and is imitating Freud's reach toward a mental object behind appearances.

So here's my list of attitudes--the founding attitudes of psychoanalytic treatment. Do you

recognize this picture? Endless curiosity; endorsement of the patient's thrust; an evocative sort of affection; a faithful intimacy; a nervous dance around any illusion of lasting attachment; a demand that the patient rise above his wishes and face the truth; constant skepticism about all appearances; a lightness about the patient's dramas and the drama of treatment; absence of role and judgment. And I might add, as I mentioned at the start, a studied disingenuousness, that is, an attitude of innocent observation.

Well, what do you say? You say: yes, the portrait does convey a faint likeness and it might look better in a dark corner of the attic. What a dull list of hateful attitudes! What about plain human affection? How about casing pain, defeating demons, mastering fate? Where is the playfulness and creativity, the enlargement of experience? Where is the excitement of surviving risky genuineness? Aren't *these* the daily rewards for which analysts rise in the morning and go to work? And I say, yes, you are right, analysts do go to work for those reasons. They can do that because the *workplace* is there, assured by their taken-for-granted, baseline attitudes. My caricature is an underdrawing of the workplace--or the laboratory, as I shall presently describe it. But even as such, I confess, it lacks one identifying feature that has been the subject of ardent controversy. I must now add a note about what might be called the analyst's attitude of incubation.

We saw that Freud first achieved mastery by hitching his research wagon to the patient's memory machine. But even in 1912 he knew that patients weren't suffering just from retained memories; he knew they also had a general *interest* that is fastened onto their parents. For a while it was tempting to think that adult life is just too difficult for these patients, and that treatment is a halfway house to being a grown-up.

The idea that patients have to grow up in treatment took deeper root when theory expanded in the 1920s. After all, the superego appraises reality not in a factual but in an attitudinal way, and it might well need some growing out of. And that impression was reinforced when, in 1923, Freud allowed that there's a sense in which patients are not split-minded but wholeheartedly oppose their treatment and, indeed, throw their whole selves into every meeting with the world. With that, I think, Freud took his first steps down a dark path at the end of which he would find so few uncorrupted egos that human development came to seem an education in cowardice adapted to a projected world, itself built out of need and fear. (That's my hyperbolic inference from Freud 1937, p. 234ff.) Don't think for a moment that the theory of signal anxiety did away with the maturational image of treatment. It is true that in later theory infantile stubbornness was no longer the villain. Freud now acknowledged that people have self-protective, good reasons for lagging behind. But the same theory told him that the world we are taught to live in is a fearful world, and if we are to free ourselves from it we have to be brave as well as wise. The need for some sort of growing up in treatment was never absent from Freud's writings, from his first mention of the repetition compulsion to the late picture of a spoiled child who is unduly fearful because he has been overprotected.

This takes us into the realm of world building and world breaking. The constructivist implications of Freud's theory were understood by his coworkers. In the 1930s Hartmann was by no means alone in pointing out that significant reality is largely social reality, and

its appreciation often a matter of having a realistic *attitude* or a realistic *perspective* and useful *reflexes*, or a composite *orientation* arranged by a *well-integrated* psychic apparatus. Being realistic involves experiencing "appropriate" *meanings*, some of them quite peremptory.

This was not the kind of mind Freud cared about; it would never be capable of free choice in a field of objective reality. But analysts with more mixed objectives were not so quickly discouraged. It did not displease them to think that psychoanalysis can help patients with their problem solving, even if the problem isn't a simple recognition of objective truth. It is largely this problem-solving paradigm that we know as ego psychology, a term that should include Melanie Klein's work.

The reality that these ego psychologists ended up with was an individualized grown-up-ness, though Anna Freud and the North Americans did not discard a factor of neutral perception.

Analysts can't relax there. If treatment aims at an individualized maturity rather than truth, the analyst can no longer act impersonally when he makes his customary demand. The demand structure of psychoanalysis presupposed an objective reality that both parties could turn to and salute. Feeling respect for truth in his bones, the analyst was reassured that his body English would be disciplined, his role responses tentative, his personal influence erasable. If the maturational view took over, treatment might end up as a cloud of encouraging perspectives mixed with bundles of shaping influences. The sympathetic and seductive features of treatment might wash away the spice of challenge.

In this predicament practitioners on both sides of the Atlantic looked to the same principle for salvation: If disciplined analysts will confine themselves to nonmanipulative interpretations, then by definition their personal attitude won't impinge on patients, and the structure of treatment will remain psychoanalytic. In other words, if an interpretation can be objective, then it doesn't matter how confused the notion of reality becomes. The call is to save interpretations and let reality fend for itself. That may seem an odd solution, but it is logical, and in many quarters during the 1950s and 1960s an idealized interpretation was fast becoming the sole repository for the threatened demand structure of analysis.

Therefore it was a matter of analytic life or death that an interpretation should convey nothing but precisely what is hidden, so that it will not transmit the analyst's persuasive attitude.

Now, that is too heavy a burden for any human communication to bear. Thus, in the eyes of those who followed, this brave first effort to preserve the structure of treatment and thereby safeguard the patient's autonomy was seen, instead, as a priestly, rule-bound formalism, smug, authoritarian, and doctrinaire--perfect, in other words, to serve as a foil for rebellion by the next generation (our generation), which, as always in history, turns contemptuously from the Academy back to nature. In this case, nature is the crucible of live treatment.

Thus, after decades of taking the structure of treatment for granted, analysts today are poking at it to see how it's built. They are systematically varying treatment attitudes and watching the results.

Consider, for instance, the objective truth demand. What happens to the rest of treatment if you remove it? Objective reality was the bulwark of analytic skepticism. We were skeptical because reality was hiding behind appearances. Respect for reality buffered the analyst against the patient and the patient against manipulation. Now analysts are trying to think about patients in terms of story lines that are free of objective truth reference. Maybe that will make patients more responsible and creative. Maybe analysts can find a more flexible discipline to replace the old truth demand. For instance, it may suffice for the analyst to simply decide to read a psychoanalytic narrative into the patient's history and behavior. Maybe just being firm in that *decision* will anchor the analyst when he is being pulled by the patient's undertow. And maybe the analyst can limit such firm decisions to that one manipulation. We shall see.

That's one experiment. There are others. Analysts are also trying to be *more* objective--for instance, by using interventions that do more neutral pointing and less perspectival describing, pointing for instance to visible and categorical affects, muffled resentments, or shifts in direction.

Some investigators maximize adversarialness: they spare no island of taken-for-granted cooperation--everything is a compromise formation. Others reduce adversarialness: their experiments will tell us whether empathic affirmation reduces the patient's masochistic collusion while yet steering clear of a social relationship. Investigators are tinkering with the old analytic attitude of curiosity. They attend less to pathology and more to the process of preconscious emergence. Even the attitude of passive observation is being experimentally altered, as analysts remind themselves that they are partly making up what they see and partly producing it inadvertently. How will that affect their ability to maintain a level scrutiny?

Despite this widespread innovation, I think all of these controversies are experiments: they do not trash the laboratory. In my opinion, few psychoanalysts would be happy with a treatment that discarded the features I've mentioned, though we may not agree on their names, or the proper balance among them. If you look closely enough, I think you will see that we are all counting on transmitted reflexes and traditions to keep the main features of treatment in place while we experiment with shades and proportions.

And there, I think, lies the answer to that old, embarrassing question: Why did psychoanalysis wall itself up in institutes and reproduce by inbreeding? Freudian theory didn't need to do that. It could have survived nibbling and adulteration--has, in fact, survived that in popular culture and the academy. But the thing that Freud discovered, the thing we know as psychoanalytic *treatment*--that is quite ephemeral. It is solely the product of attitudes. It is that crucible that needed protection.

Treatment structure has no protection outside of tradition. Without special support it might have disappeared forever, exploding into a galaxy of assorted relationships, each one molded according to how it pleased the therapist to see himself. And if treatment is the crucible of psychoanalysis, its preservation was paramount. That is something to be kept in mind today, when the threat is pointedly aimed at the treatment.

Here is my peroration: Besides their other contributions, analysts do basic research. The standard treatment atmosphere is an imaging technique for mind: general features of mind are measured as the analyst notices the attitudes he must invoke to sustain the analytic atmosphere. It is a kind of echo-cardiography of the soul. Of course it does not produce a readout in pixels. Is it then just a speculative enterprise? Not a bit. Attitudes and their impacts are features of the empirical world. As the analyst switches this attitude on and that one off, he records which combinations most brightly light up the unique analytic situation. It is the slight alterations 'in treatment attitudes that constitute experiments in this peculiar laboratory of the mind, the laboratory that is dedicated to research on the pathway of desire, the nuances of interaction, the limits of freedom, the relationship of cause and reason, the nature of meaning, the meaning of responsibility, and all the special paradoxes of humanness. I really cannot imagine what other form research on these issues could possibly take.

The supreme irony of today's psychoanalysis is that the gravest threat to its existence finds the profession in an unparalleled, efflorescent vigor--I would call it a renaissance. In that respect, at least, you must consider yourselves fortunate.

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