14 *The Purloined Self*

YOU ARE ALL, I'M SURE, FAMILIAR WITH EDgar Allan Poe's famous story, "The Purloined Letter." A document of vital significance to the resolution of a crime is left sitting totally in the open, in the most obvious location; indeed, so obvious that no one thinks to look there. It is hidden by being exposed. I wish to make much the same point about the data of psychoanalysis: that is, the most "hidden" data are often sitting right under one's nose. The data of psychoanalysis—I would claim—are simple, almost banal. Patients' fantasy elaborations of their experience are often quite elaborate and dramatic, but the experience which underlies the phantasmagoria may be disarmingly familiar. Please note that this is an interpersonal perspective, placing primary emphasis on intersubjective experience. From this perspective, fantasies—however imaginative or striking—are not considered to be the motivating force of distortion. Rather, they are seen as an effort to grapple *with* distortion, which can be defined as experience mystified by anxiety.

Ask an analysand who has completed a successful analysis what it is that he or she has learned. The response tends to be rather diffident. Post facto rehashes of psychoanalysis tend to be obvious and cliché-ridden, glosses of the therapist's favorite metapsychological musings. Well, it is not very comforting for us to think that we are merely apostles of the obvious. We prefer to believe that, in exercising our craft, we are arriving at something *really* buried down deep: arcane and ominous. This is what has been called the "Rumplestiltskin fallacy," Rumplestiltskin being, as you surely remember, the evil and vengeful dwarf who vanishes when his name is known. So, depending on our metapsychological bent, we unearth infantile experience (or fantasy of experience), early evidence of parental empathic failure, fear

of separation and loss, Oedipal conflict, or, perhaps, subtle discontinuities in interpersonal experience. And when the Name is spoken, we expect the exorcism to occur. Yet sometimes the magic doesn't work, even when the explanations qua interpretations seem patently true. Why not? What's wrong with a good theoretical interpretation? Perhaps it is as Bion said of his analysis: "Sometimes I felt that Mrs. Klein was as eager to teach Klein as to analyze Bion" (quoted in Boris, 1986).

Faced with the failure of meaningful interpretation to work, psychoanalysts became interested in *why* the Truth did not save. So psychoanalysis discovered resistance and transference, surely the sine qua non of psychoanalytic therapy. Why is there resistance to change? From the drive theory view, it is resistance to insight, to what is *there* to be seen. From the interpersonal view, it is the perspicacious discovery that the leverage of psychoanalysis lies not so much in *what* is learned but in comprehending what a complex interpersonal experience it is *to* learn, in collaboration with another person. Resistance and transference, as Merton Gill has pointed out, are the same phenomenon of recalcitrance viewed from two different perspectives (Gill, 1982). We call it resistance when we wish to conceive of the recalcitrance as directed against the content, i.e., as an unwillingness to hear the unpalatable Truth. When we wish to view the recalcitrance as intersubjective—directed against the analyst—we call it transference.

I do not mean to imply that interpretations are always benignly irrelevant. They can be biased, politicized, and coercive. But it is the relationship with the therapist around the interpretation which matters. I do believe that the most reactionary metapsychology can be used respectfully by a respectful analyst, and the most ostensibly benign and humanistic metapsychology can be used coercively by a manipulative analyst. The metapsychology does not readily constrain the therapist. As the National Rifle Association is wont to say: Guns don't kill people, people do! Perhaps it is not interpretations that are destructive, but analysts.

More often than not, though, what the analyst has to say is not necessarily all that unpalatable. As Jacques Lacan put it: "The therapy is finished when the patient knows what the therapist knows, which is what the patient has always known" (Lacan, 1977). That puts the issue nicely; the task in therapy may be seen as getting the patient to acknowledge—to "own"—awareness that has been selectively inattended. One is not telling the patient anything he or she doesn't already know, on some level of awareness. What may matter a great deal

is *who* you are for the patient and *when* you tell him what you know he knows. The function of an interpretation—and this is very important—is not so much to tell the patient something new, but to inform him that you are prepared to countenance what he has to tell you. For example, to say to a patient, "Perhaps you are angry at me," is not to interpret a hidden affect as much as to acknowledge the anger, to indicate that the *analyst* is not too anxious to hear what is there to be heard. Countertransference, from this view, is what the therapist cannot bear to hear.

This puts the "data of psychoanalysis" in a peculiar light: I claim that psychoanalysis is a bootstrap operation, that is, we are trying to lift the patient and ourselves out of a field in which we are *both* imbedded. This is, of course H. S. Sullivan's famous participant–observer thesis. We do not stand outside of the field we are observing. Ergo, the therapist becomes part of the problem he is trying to solve! Therefore, interpretations fail to move the patient, not necessarily because they are wrong or right, but because the therapist lacks the necessary interpersonal *leverage*.

This principle is nothing less than the definition of transference and resistance from a radical interpersonal perspective. The intrapsychic view is that the patient is resistant to awareness because of his intrinsic defenses against knowing what there is to be known (fantasy or reality). The interpersonal view is that the patient resists awareness because he or she has always been, and still is (with the analyst), in relationships which *preclude* awareness because awareness provokes anxiety in all present.

This may sound like a rather arbitrary and extreme dichotomizing. Let me give you two clinical examples illustrating somewhat different aspects of the problem: first, that the data of psychoanalysis are sometimes simpler than one is led to expect; second, that the problem in initiating change is not the data per se but the therapist's relationship to the data.

This first case is of a woman aged 27 who suffers from agoraphobia and acrophobia. She cannot leave her home unaccompanied. In therapy she recalls her first episode of acrophobia, at age 17. She had been returning from the West Coast with her family: her father, mother, and her older sister, aged 20. In the car, going to the airport, her mother and sister squabble over who will get the window seat on the plane. Her father listens quietly for a while and then snaps at the mother: "For God's sake, let her have the window seat!" On the flight, the patient is reading *Deliverance* (a book about machismo rites

of passage). She gets 70 pages into the book (the plane had already taken off) and has a severe anxiety attack! Her father (who is also an acrophobic) gives her two of his Valiums.

I first heard this episode presented by a candidate in a class, and I have tried it out many times since. To my absolute amazement, although a number of ingenious interpretations were posited, *no one asked who got the window seat*! Without that purloined piece of data, so obvious that no one bothers to ask it, we cannot know the lines of force in the family. Is the father all powerful, inducing an infantile, regressed bickering among his harem? Or, is he helpless in the face of the mother's narcissism, her claim to be the center of interest? Or, is the mother simply asserting her seniority rights: Why shouldn't she have the window seat? Do they bicker over the seat to humiliate the father, who is too terrified to look out the window? As the Cabalists put it, "The Mystery of God lies in the particular." The mystery of interaction lies in the details, the "obvious" details, which are not asked.

Why are they not? There is clearly a collusion *not* to notice, *not* to see what is there, under one's nose, to be seen. As someone once said, the essence of hard science is, "Who would have thought!" whereas the essence of the social sciences is, "Well, now that you mention it." Once one thinks of it, it is inconceivable that the crucial question was not asked. Yet, it wasn't.

The therapist agrees with the patient to selectively inattend this bit of data. Certainly this is countertransference. But it is also the tendency of therapists to listen to what the patient has to say and then to try to make sense out of it rather than looking for the data purloined. As Bion put it, "[one needs] a flash of the obvious. One is usually so busy looking for something out of the ordinary, that one ignores the obvious as if it were of no importance" (quoted in Colbart, 1986). Let me reemphasize that, in this case, the issue is not the interpretative set: Many valid things could be said about this family's interaction. The problem is that interpretations can become premature attempts to organize the patient's perceptions.

The second case, a segment of a therapy reported by Joseph Sandler, illustrates these issues in the praxis of a very experienced and sophisticated therapist (Sandler, 1981). This is a woman patient who cries in every session. Dr. Sandler, each time, passes her what I presume to be his box of tissues, since he says that he expects, ordinarily, that patients bring their own tissues or use a handkerchief. He is not clear why he concedes to her. "One day something rather unusual happened in the analysis." This time, she cried and he did not come

across. She upbraided him angrily for failing to respond. Dr. Sandler admitted that he did not know why he had failed to give her the tissues this time, but "suggested that she go on talking and they might understand." It "turned out" that the core issue—the fear that dominated her life—was "that she might soil herself *and there would be no adult there to clean her up*." The discovery and working through of this fantasy marked a crucial point in her analysis, says Dr. Sandler. He then proceeds to say that he thinks he picked up unconscious cues from the patient, which led him to behave first like an attentive mother and then, later, a parent who would not clean her up.

It is clear that, for Dr. Sandler, arriving at the unconscious fantasy which underlay both her dynamics and her interaction with him was the crucial act. That this fantasy crystallized out of a particular infantile experience is made quite clear. But it is (for Dr. Sandler) equally important that the infantile experience stimulates an unconscious fantasy system which has an impetus and life of its own. Her behavior with him is a drive derivative. Thus, he operates with her around the fantasy as a piece of projective counteridentification. The data of psychoanalysis, for him, are, first, her actual history—not very elucidated, more a landscape of markers—and, second, her fantasy translation of those events, and lastly, their mutual participation in an "acting in" around her fantasy. This seems to me a perfectly plausible intrapsychic version of her experience.

But if one reviews the events of her childhood not as stimuli of a fantasy system but as integral events, a somewhat different perspective emerges. Although we are told that at age two a baby brother entered the picture and she began to throw tantrums and be withdrawn at school, we are not told what anyone did about it, what attempts were made to comfort her or offer her some substitute gratification for her loss of sibling primacy. We do not know whether the son was preferred or, if so, why. In a word, there is no sense of human interaction, how they proceeded with each other, no feel for social context, the empathic efforts and the mystifications of experience that are part of any family. Therefore, when an isomorphic replay takes place in the therapy, Dr. Sandler is not particularly interested in the nuances of the interaction, either as it occurred in childhood, or as it is occurring between them now. Their exchange is seen merely as the jumping-off point for her fantasy.

One might wonder whether the patient as a child was able to terrify everyone into attending to her, or was she unable to get anyone to attend to her? What are her other adult relationships? Do her current man friends, or woman friends, feel obliged to meet her demands? Is

she self-effacing or tyrannical? When, how, or with whom? Aren't these vital data for judging the subsequent exchange in the therapy? All I can see is that Dr. Sandler—as he admits—felt intimidated by her and obliged to give her tissues: When he didn't, she blew up. Surely this is a repetition of something with the parents, but what?

For that matter, why doesn't Dr. Sandler keep a box of tissues handy for his patients? Should they have to bring their own? Were the tissues beside Dr. Sandler's chair? Were they then *his* tissues? What does this say about Dr. Sandler's attitude about patients' crying? Why doesn't he comment on why he does it this way?

Did she catch him out, see something about him that his other patients inattended? I think she provoked him to break his own rule by playing on his anxiety (his dissociated reasons for having the rule in the first place). His later refusing the tissues was a reassertion of control (and presumably neutrality), but it was also a tacit admission of his own participation, that the entire interaction has some special meaning for him that came out of his own experience. Surely, it was stimulated by the patient's unusual recalcitrance to his rule. But it was not put into him by the patient, as the rather self-serving concept of "projective counteridentification" would suggest (Grinberg, 1962).

If one considers the patient–therapist relationship as a complex matrix of interpersonal events with strategies, evasions, and inattentions, then her experience with Dr. Sandler is more understandable as a replay—in the room—of the very sort of interaction which has made trouble for her and still does. Why did he not respond this one time? I think his explanation is inadequate and leaves him entirely out of the equation. There was *some* perception of her, albeit marginally perceived, that made him decide to stand his ground this time and not demonstrate the sympathy she demanded.

In both these clinical examples, I believe that the significant data are almost banal, on the surface, albeit in different ways. In the first case, one need only have continued the detailed inquiry a bit further instead of trying to make sense out of what the patient volunteered. In the second case, the therapist ignored the nuances of his mutual collusion with the patient in favor of an "underlying" fantasy: something primitive, infantile, and esoteric—the "Ah-ha! Now we know what it is all about!"

Who got the window seat? How did I get into this tissue business with her? These questions seem too superficial. But as Oscar Wilde once put it. "Only superficial people insist on looking beneath the surface." I have never, in my clinical experience, resolved a therapeutic

impasse without thinking afterwards, "My God, that was so obvious, why didn't I see it!" Never, "Who would have thought!" but rather, "Now that you mention it." Countertransference, operationally, is what we do not think to ask.

Let me focus this a bit. I have said that the data of psychoanalysis are often so obvious, so in the open, that we do not look for them. Let me define more specifically what I mean by "data." The data of psychoanalysis are acquired through the detailed inquiry, again H. S. Sullivan's phrase. The therapist collects information from the patient: history, early experience, present difficulties, dreams, fantasies, loose associations. You will note that I lump both relatively free-associative flow and focused inquiry together. I do not think they are different processes; both tap into the flow of consciousness. For example, in the most concrete inquiry into the details of a reported event, strange things begin to happen. The inquiry tends to go off in unexpected directions. The detailed inquiry is a kind of deconstructionism: I mean simply that when one breaks down the surface of an inquiry, and pursues the details, an entirely new level of meaning emerges.

This is not so difficult to conceive, assuming that the patient's account is, like a Swiss cheese, full of holes produced by anxiety and dissociation. The patient does not dare to see what is there to be seen because, as I said earlier, in his or her experience great anxiety and discordance was called out in the significant parenting person and *still* is called out. So, the inquiry puts its foot into these holes.

As the therapist proceeds, he or she willy-nilly becomes part of the inquiry since what is asked, what one thinks to inquire into, will depend on who the therapist is, what his or her experience has been. So, the relationship with the therapist develops *out of the material* under inquiry. Inquiry provokes anxiety, anxiety provokes resistance, and resistance is manifested as transference, a totally consistent version of the process (Gill, 1982). Thus, a radical form of detailed inquiry can, as much as free association, lead to an emergence of a transference, but not an orthodox transference, because it is conceived as *real* experience with the therapist, not as the patient's fantasy projections onto the therapist.

I would suggest that most of the trouble in psychoanalysis arises because the therapist listens to the patient's account and then, instead of looking for the holes in the story, tries to make sense of it as presented, tries to formulate, in the mode of his or her metapsychology, some rational framework for understanding. Perhaps it is better to *ask in detail about anything*, as Sullivan once told a therapist when she was

stymied. This is not so dissimilar from Freud's admonition to a patient who said he couldn't free associate. "Well," said Freud, "tell me about the thing furthest from your mind!"

So the first face of the data of psychoanalysis is the inquiry. The second face is what happens between patient and therapist in the process of this inquiry. Bear in mind again that I am defining this as *real*, an actual mutual experience, not a projected fantasy. And it is the correspondence of the data elicited from the inquiry and the data elicited from the relationship which constitutes the quintessential psychoanalytic event. It is what is *done* about what is *said* that matters.

So, for me, the real issue is not in deciding what are the relevant data of psychoanalysis, i.e., what is worth finding out about. It is, rather, any detailed deconstructive inquiry (free-associative or detailed inquiry) matched against the development of an isomorphic pattern in the therapy relationship. In essence, then, to present it as a paradox (which it is, and which most creative events are): Psychoanalysis works because the therapist can show the patient that it *cannot* work because what is occurring between them is the same as what they are talking about. Psychoanalysis works because it is unworkable; that separates it from psychotherapies which work (when they work) because they are preeminently reasonable attempts, by an expert, to organize and structure the other person's life as it is presented to them. The shortcoming of psychotherapies is that they often lean heavily on the patient, pressuring him or her to see something and change. Often, the result is a deeply submerged rebelliousness for which the therapist (or the patient) pays heavily in the end. Change that comes from the therapist's actions is usually *reform*. Real change follows the failure of the therapist's magic. Then, it is intrinsically the patient's.

The patient must be impressed with the homeostatic power of his or her own system. It is because he or she is in a hall of mirrors that change becomes possible. Perhaps working through and repetition compulsion have something to do with the difficulty of shifting the system. Does the replay cause small but vital shifts (assimilation-accommodation), or does the failure of the system to shift finally impress the patient with his or her own boundaries? Does psychoanalysis establish an interface between patient and therapist? Many of our patients come from families where the problem was not so much lack of affection but a narcissistic assumption that the child is who the parent wants him or her to be. The child then has no sense of boundary, of separateness. Hence the paradox of treatment: If the therapist knows what is wrong with the patient, then the patient is invaded to be cured; if the patient protects his or her shaky boundary, then he or she

must refuse the help of the therapist. If you tell this to the patient, can he or she stop? Wouldn't that be exactly the invasion the patient must repudiate to achieve autonomy? Once the patient stops listening to you and starts listening to himself talking to you, change becomes possible.

To summarize what I've been saying: First, the data of interpersonal psychoanalysis are the interactions of the person in his or her intersubjective world. These interactions are reflected upon in fantasies and dreams but are not derivatives of fantasies, i.e., they are not fantasies emerging as social reality. This is, of course, to some extent also true of object-relations and self-psychology theory (Greenberg & Mitchell, 1983). But the second point is quite different, namely, the significant data of psychoanalysis are obscured, hidden, not because awareness is in itself threatening (repression), but because acknowledgement of what is "inattended" is extremely anxiety provoking to the patient's social surroundings, i.e., the significant others in his or her life, including the analyst. Anxiety, as Sullivan put it, is a "contagious" phenomenon (Sullivan, 1948). Data are not buried down "deep"; they are simply not noticed, selectively inattended. Freud's repression is vertical; Sullivan's inattention is horizontal. One might consider that attention is like a sharply focused flashlight on a dark field; our function is to broaden the beam. The difficulty in doing just that is the analyst becomes part of the collusion to not see.

Perhaps, as C. Auguste Dupin, Poe's famous detective, put it: "Perhaps the mystery is a little *too* plain. . . . They consider only their *own* ideas of ingenuity, and in searching for anything hidden advert only to the modes in which *they* would have hidden it. When under stress, they tend to exaggerate their own modes of *practice*—without touching their principles" (Poe, 1938). To look with a fresh eye is to see what is obvious to everyone except the expert, with his preconceived version of reality.

References

Boris, H. H. (1986). Bion revisited. *Contemporary Psychoanalysis, 22*:159–184.

Coltart, N. C. (1986). Slouching towards Bethlehem, or, thinking the unthinkable in psychoanalysis. In G. Kohon (Ed.), *The British School of Psychoanalysis: The Independent Tradition*. New Haven: Yale University Press.

Gill, M. (1982). *Analysis of Transference*. (Vol. 1). New York: International Universities Press.

Greenberg, J., & Mitchell, S. (1983). *Object Relations in Psychoanalytic Theory*. Cambridge, MA: Harvard University Press.

Grinberg, I. (1962). On a specific aspect of countertransference to the patient's projective identification. *International Journal of Psycho-Analysis, 43*: 436–440.
Lacan, J. (1977). *Écrits: A Selection*. New York: W. W. Norton.
Poe, E. A. (1938). The purloined letter. In: *The Works of Edgar Allan Poe*. New York: Harper & Row.
Sandler, S. (1981). Unconscious wishes and human relationships. *Contemporary Psychoanalysis, 17*: 180–195.
Sullivan, H. S. (1948). The meaning of anxiety in psychiatry and life. *Psychiatry, 11*: 1–13.