A SESSION FROM “SESSIONS”

There was a program on cable TV called Sessions. Each episode was organized around a session of psychoanalysis or psychoanalytic therapy, depending on your point of view, with various flashbacks to scenes from the patient's current life situation and childhood as the patient described them. In one episode the patient's mother had a scare. She's been hospitalized with a heart condition, perhaps a mild heart attack. The patient is on the couch. The analyst or therapist, played by Elliot Gould, comes across as warm and engaging. The patient, who appears to be between thirty-five and forty years old, is estranged from his father. He complains to the analyst about how his father is so self-centered that even under these circumstances he could only think of himself. The patient describes his experience with his father driving home from the hospital after visiting the mother. We see the flashback. In the car the father goes on about his

An earlier version of this paper was presented at the symposium: Intimacy and Boundaries in the Psychotherapeutic Situation, Massachusetts Institute for Psychoanalysis, Cambridge, Mass., October 31, 1992.

1 For a discussion of conceptual and terminological issues regarding the relationship between psychoanalytic psychotherapy and psychoanalysis see Gill (1991). In this paper the terms psychoanalysis and “psychoanalytic therapy” and the terms analyst and therapist will be used interchangeably. “Psychoanalytic therapy” is Gill's term for the modality utilizing psychoanalytic technique without the couch and without the conventional frequency of psychoanalysis proper. The modality that interests me, whatever it should be called, entails a dialectical interplay of suggestive influence and critical reflection on the interaction.
anxieties over handling household duties. He doesn't know where things are, he doesn't know how to cook, he feels helpless. In the session the patient is irate because his father conveyed no concern about the mother's well-being. At some point the analyst asks: “Do you think he's scared?” Caught by surprise, after a pause the patient replies, “Yes, I suppose so.” The analyst says, “Maybe he needs someone to talk to about it.” The patient says: “My father? You mean talk to a shrink-type person like you? Are you kidding? He'd never do anything like that.” The analyst says: “Actually I wasn't thinking of a shrink-type person like me. I was thinking of a son-type person like you.” The patient exclaims: “Are you crazy? My father and I haven't had a real conversation my whole life. Why in the world would we start now? That's just ridiculous!” After a pause the analyst says: “It's not a suggestion, you know, just a thought.”

In the ensuing scene the patient is with his father in the kitchen of the parents' home. Their backs are to the camera as they stand in front of the kitchen counter. The father is stocky and somewhat shorter than the patient. He seems to be in his sixties, maybe early seventies. They are preparing dinner. The father is fumbling around looking for utensils and other things. He drops something and picks it up. He is chattering nervously about how impossible it is for him to get along. He seems weary and leans for a moment against the counter. The patient asks, quietly, “Dad, are you scared?” The father is silent. He nods yes, sighs, and says, “Yeah, I am.” After a moment the two simultaneously lean toward each other, and the patient puts his arm around the father who leans his head on his son's shoulder. The scene fades and the program ends.

**REVISITING THE MYTH OF ANALYTIC NEUTRALITY**

For the sake of illustration, if we treat the episode as if it were one from a real analytic therapy, no doubt there are many other
things the therapist might have done or said. He could have been silent, for example, with the idea that he needed to hear more before feeling that he had something pertinent to say. Alternatively, he might have expressed empathy with his patient's anger at his father for being so self-centered. In that context he might have encouraged associations to this experience with some special interest in its historical antecedents. Another possibility might have been to listen for and eventually try to interpret the latent transference meanings of this particular set of associations. Is there something in the content that alludes to an aspect of the patient's experience of the relationship with the therapist, or is there a desire for something from the analyst that is implicit in the patient telling about this experience at this moment? Indeed, perhaps the analyst's knowledge of the patient's history and his awareness of various aspects of the transference would lead him to interpret a conflictual wish for guidance about how to respond to his father's behavior. In that context, presumably, the analyst would interpret without actually advising or suggesting anything, in keeping with what might commonly be recognized as a proper, relatively “neutral” analytic attitude.

In fact, all the alternatives I just mentioned have a decidedly more neutral appearance than what the analyst or therapist does in this instance, which is to offer, despite his transparent disclaimer (“just a thought,” he says), a blatant suggestion of something the patient might do. Hypothetically, there could be enough in the background of such apparent “advice” for it to carry more implicitly interpretive meaning. For example, the patient and the analyst might have developed an understanding that the patient shies away from opportunities for emotional contact with his father. In such a context, the analyst's overt suggestion might imply a question such as: “Is this another instance in which you are refusing to think in a more sympathetic way about what your father may be feeling?” Without that context, however (and maybe even with it), many would view the analyst's comments as appropriate at best for counseling or supportive
psychotherapy rather than for psychoanalysis or for any rigorous type of psychoanalytic psychotherapy. According to that perspective, the last thing a good analytic therapist wants to do is cross the boundary that separates him or her from direct involvement in the analysand's life. Instead, analysts aspire to help their patients become aware of the unconscious issues and conflicts that are affecting their adaptation so that their choices can become more integrated and more informed. To meddle in the patient's affairs is to inject one's personal prejudices at the expense of elucidating the patient's unconscious motivations and internal object relations, his or her "intrapsychic life." In the end, if there are difficult choices to be made in "real life," it is the patient who has to make them on his or her own. The aim of analysis, to paraphrase Freud (1893-1895, p. 305), is to transform neurotic suffering into normal human misery. Our responsibility ends where the patient's begins.

But is this portrayal of the process accurate? Suppose the analyst in the situation I described did offer one of the more ostensibly neutral types of responses. Suppose he just listened, or empathized with the patient's anger, or tried to interpret the latent meaning in the transference. What might have been the result? Would the patient have asked his father whether he was scared? Would that poignant moment of closeness have occurred? Perhaps. But it seems reasonable to think that the probability of that happening might have been less. Of course, the analyst's presence as an immediate influence is unmistakable when the patient asks the very question the analyst posed in the hour. Indeed, we think immediately about the dangers of behavioral compliance and/or identification with the analyst at the expense of other aspects of the patient's experience. But if the analyst did not make that conspicuous suggestion and the patient did not ask his father that question and did not thereby make himself available as someone the father might talk to about his fears, would we recognize the influence of the analyst in the not-asking and in the non-occurrence of that moment of closeness with all its potential for further development? My
guess is that we would not. Instead, we would think of the patient as simply doing what he chose to do in keeping with his characteristic way of relating to his father. The analyst, we would say, didn't have anything to do with it; his hands would be clean. All he did was follow the patient's lead and explore various aspects of the patient's conscious and unconscious experience.

That is all very neat but also quite illusory, in my view. Whatever the analyst does is invariably saturated with suggestion (Gill, 1991). To follow whatever one decides is the patient's lead, to choose to pick up on one or another of the patient's more or less ambiguous communications, is also to lead the patient in a particular direction (Hoffman, 1990). If the analyst empathizes with the patient's anger, for example, he might well be suggesting, consciously or unconsciously, that it would make sense for the patient to continue to keep his distance from his father, at least for the time being. It might be argued that that last qualification (“for the time being”) is quite important. If there is an apparent tilt at the end of a session in one direction or another, that hardly means the last word on the subject has been spoken. There will be plenty of time, one might argue, to get to other aspects of the patient's experience and to explore them, including, perhaps, a disclaimed wish for closeness with the father along with an unconscious fear of it. There is never any hurry in psychoanalysis. In due time many more or less conflicting facets of the patient's experience will come to light, and we will be in a position to demonstrate how evenhanded we can be in according due respect to all of them.

The trouble with this reasoning is that it denies that analysis goes on in real time—time that really counts—and that the patient is continually making real choices under our suggestive influence both within and outside the analytic situation. A common illusion that I think we try to maintain is that analysis is a kind of sanctuary from the world of choice. We have the idea, in that regard, that people should postpone certain choices until they know more about what they mean in terms of the underlying
unconscious conflicts that are involved. Undoubtedly, that delay may be possible and even invaluable in some instances, but even then, of course, the postponement itself is a real choice with real consequences.

I think that the idea of analysis as sanctuary, taken too literally, denies both the extent of our authority and the extent of our intimate involvement with our patients as they risk doing or not doing one thing or another both inside and outside the analytic situation. In trying so hard to stay out of it, we can really be “out of it.” Opportune moments for action come and go. They do not necessarily recur, and they certainly do not last forever. The analyst is right there in the patient's life as those moments pass by. There is no risk-free position to which he or she can retreat. In the example I presented from the TV program, if the analyst adhered to the relatively passive and seemingly “neutral” mode that I think is idealized in many of our theories, that father might have died before the patient stumbled upon his own desire for, and his capacity to create, that special moment of intimacy, not to mention the amount of precious time that might have been lost even if such a moment did eventually occur.

I do not think it is melodramatic to consider those possibilities. Although it is rather pervasively denied in psychoanalytic theory (Becker, 1973; Hoffman, 1979), death is a rather common interference with our best laid plans. In a basketball game or a football game, a team can at least call time-out, and the game clock literally stops while the team members collect themselves, soul-search, and strategize with the assistance of their coach. But a person's lifetime keeps on going relentlessly through every analytic hour, week, and year. The clock keeps running, and more or less agonizing choices are being made continually, with the analyst's witting or unwitting participation, right under his or her nose. If the analyst chooses to be silent or detached, he or she is nevertheless responding and participating. The effect of that silence or detachment is not simply to bring out “the truth” regarding the nature of the patient's desires; rather, it is to
affect and partially shape those desires and their expression at any given time both within and outside the analytic situation itself.

**COMING TO GRIPS WITH THE ANALYST’S AUTHORITY IN A CONSTRUCTIVIST PARADIGM**

These days it is commonplace to acknowledge that we are not involved in the therapeutic process merely as objective scientists. We recognize instead that some benign aspect of our interpersonal involvement is intrinsic to the therapeutic action of the process (e.g., Bromberg, 1983; Kohut, 1984; Loewald, 1960; Strachey, 1934; Winnicott, 1971), that our theories inevitably affect the kinds of interpretations that we pursue (e.g., Schafer, 1992; Spence, 1982), that our countertransference attitudes are more pervasive, consequential, and potentially useful than what has traditionally been considered to be the case (e.g., Bollas, 1987; Ehrenberg, 1993; Gill, 1982, 1994; Greenberg, 1995; Hirsch, 1993; Jacobs, 1991; Levenson, 1983; McLaughlin, 1981; Mitchell, 1988, 1993; Racker, 1968; Renik, 1993; Sandler, 1976; Searles, 1978-1979; Slavin, 1994; D. B. Stern, 1989; Tansey and Burke, 1989), and that we have to keep an eye on the way in which our own personal values may result in our trying to influence the patient in one direction or another (e.g., Gedo, 1983; Hoffer, 1985; Lichtenberg, 1983; Meissner, 1983; see entire issue of *Psychoanalytic Inquiry*, Vol. 3, No. 4, 1983: *Values and Neutrality in Psychoanalysis*, M. Bornstein, Editor).

But to what extent do we merely pay lip service to these realizations? Even when the ubiquity of suggestion is acknowledged, the emphasis usually falls almost entirely on analyzing its effects in order to minimize them. How much do we embrace the fact that, whether we like it or not, we are inevitably involved in some measure as mentors to our patients? To accept fully that aspect of our role is to appreciate that it is not enough to say that

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our actions should always be subjected to analytic scrutiny. We also have to try to act wisely even while recognizing that whatever wisdom we have is always highly personal and subjective. In fact, because of that recognition, we do not like to think that we influence patients in regard to life-shaping questions, such as what career to pursue, what sexual orientation or quality of gender identification to adopt, whether or not to marry or even whom to marry, whether or not to try to have or adopt children, whether to reach out to estranged parents or sever ties to them, whether to take a certain political risk or not, or even whether or not to say a particular thing to a particular person between one session and the next.

Within the analytic situation as well, we want the patient to be the one who shapes the atmosphere of the relationship with little or no “interference” from us. When we interpret the transference, we like to think that we are merely bringing to the surface what is already “there,” rather than that we are cultivating something in the patient and in the relationship that might not have developed in the same way otherwise. We still like to believe that our influence on our patients’ choices is limited to helping them become aware of the various aspects of their own inner conflicts as they shape the alternatives they feel they have. Perhaps with our new sophistication we have increased conviction that we cannot take our neutrality for granted even after we have formally terminated our own analyses. But I think we have clung to the idea that with continual hard work, analysis of transference and countertransference, and critical reflection, we can neutralize our personal and theoretical prejudices so that their effects will be negligible. Continual doing and undoing, that is the new solution. Our hands are not clean; we all know that now. But we figure that if we keep washing them maybe we can still get rid of most of the dirt (or the blood), or at least enough so that what remains will not be detectable even by ourselves.

But this strategy simply will not work. Those of us, especially,
who have turned away from an objectivist view of the analyst's role and replaced it with the view that the patient's experience is partially constituted interactively in the analytic situation, in other words, those of us who have been trying to work out a “constructivist” view of the analytic process are faced with the necessity of coming to grips with the full implications of that perspective for the role of the analyst in the patient's life. If we believe that the analyst is involved in the construction rather than merely the discovery of the patient's psychic reality, we are confronted with the fact that, according to that view, there is no way to reduce one's involvement to being merely that of a facilitator of self-awareness or even integration. There is no objective interpretation and there is no affective attunement that is merely responsive to and reflective of what the patient brings to the situation (Cushman, 1991; Seligman, 1990). There is always something personal and theoretical (the theoretical being an aspect of the personal) that is coming from the side of the analyst. Moreover, there is always something about that that is unknown, either because it is resisted or because it is simply beyond the patient's and the therapist's frames of reference. Whatever we can become aware of regarding the cultural, theoretical, and personal-countertransferential contexts of our actions, some things are always left in the dark. One might say that one of the contexts of our actions is always the context of ignorance of contexts. And yet, act we must. We have no choice about that. So along with awareness of our inevitable partial blindness, we can also recognize that the analyst is positioned right in the middle of the action, struggling with patients as they decide what to make of their lives, past, present, and future.

Let me pause here to say something about the term “constructivism.” I realize that the term has a variety of meanings in philosophy, in literary theory, in sociology, and in psychology. Mahoney (1991) distinguishes between “radical constructivism,” which connotes a virtually solipsistic relativism, and “critical constructivism,” which connotes an interaction between a partially
independent reality and the activity of human subjects. My use of the term constructivism is probably closer to what Mahoney means by “critical constructivism.”

Neither the patient's experience nor the analyst's is some kind of Silly Putty that is amenable to any shape one might wish to impose on it, and, of course, even Silly Putty has properties that limit what can be done with it. Constructive activity goes on in relation to more or less ambiguous givens in the patient's and the analyst's experience. In fact, some of those givens are virtually indisputable elements in the experiences of the participants, and any plausible interpretation would have to take them into account or at least not contradict them. This goes for interpretations by each of the participants of the experiences of the other as well as for interpretations that each directs toward himself or herself. Moreover, even the ambiguous aspects of experience are not amorphous. They have properties that are amenable to a variety of interpretations, maybe even infinite interpretations, especially if we take into account all the nuances that language and tone make possible. But infinite does not mean unlimited in the sense that anything goes. There are infinite numerical values between numbers 5 and 6, but that range excludes all other numerical values.

Having recognized that, we can return to consideration of the constructive aspect of conscious and unconscious human action. Because its root is a verb denoting shaping and creating, I prefer the term constructivism to perspectivism (Hoffman, 1991, 1992c). Let me add that I do not believe that constructivism in the context of studying human experience as such should carry the same meaning as constructivism in the physical sciences or in literary theory. Experience, taken as a whole, is partially constituted by what we make of it, retrospectively, in the context of interpretation, and prospectively, in the context of experience-shaping actions (Hoffman, 1992b). I do not believe that the

2 One of the variety of things that we can do at any given moment is to reflect upon and interpret what has gone on in the recent or distant past. Of course, the experience in the past as it happened at the time cannot be changed by any retrospective view of it. Thus the term “constitute” has different meanings in the retrospective and prospective contexts (E. Gillett, personal communication, 1993).
same could be said reasonably of the motion of the planets or of the literal contents of a completed written text. The planets and the existing text have a different sort of independence from the organizing activity of human subjects than does the flow of those subjects' experience during any given interval of time (see Taylor, 1985).

Howard (1985), writing on the role of values in psychology, while taking due note of the effects of the observer on the observed in the physical sciences, argues that in the social sciences and in psychology in particular there is a further consideration:

The form and characteristics of any creation are, in part, a reflection of the creator. This is true even in the natural sciences, where the theory bears the mark of the theorist. But I am arguing that subjectivity cuts yet a second way in psychological theory and research: Human action, the explanandum of the theory, can also change in reaction to the theory. Therefore, although the psychologist shares with the natural scientist the task of explaining the present action of his or her object of study, the psychologist has a further injunction: to consider what human beings might become in response to our research.

Viewed from this perspective, psychologists are seen as agents in the formation of human beings …. researchers should modify their ambition to become disinterested parties or value-free agents. It seems that a more adequate solution would involve acknowledging and accepting the place of values in their endeavors (p. 262).

What Howard says of researchers applies in spades, of course, to psychoanalysts in the clinical situation.

As part of our involvement with our patients in their struggle to shape their lives, we do, of course, work hard at reflecting critically on the nature of our participation in the process. There
is an ongoing tension and oscillation between the conscious and unconscious building up of “realities” in one sphere or another and reflection upon how, why, and at what cost those particular constructions arose and became more or less calcified. Within the analytic situation, one might say there is a tension between allowing ourselves to get caught up in various kinds of interactions with our patients, on the one hand, and disciplining ourselves to step back to reflect critically on the meaning of our involvement, on the other. To some extent free association, as the central focus of analytic attention, is replaced in this model with the free emergence of multiple transference-countertransference scenarios, a sample of which is more or less reflected upon and interpreted over time. To say this is not to deny the central place of the patient's “psychic reality.” The transference-countertransference patterns that emerge bear the stamp, in part, of the patient's internal object relations as they are externalized in the analytic situation (Bollas, 1987; Hoffman, 1983; Racker, 1968; Sandler, 1976; Searles, 1978-1979). One of the potentially useful functions of countertransference disclosure is that it can bring into the open particular transference-countertransference tensions that may be hovering in the atmosphere of the relationship at any given moment.

Beyond the difference, however, between an emphasis on free association and an emphasis on the emergence of transference-countertransference configurations there is also a difference between analytic experience understood as representational or figurative and analytic experience understood as “actual” or literal (cf., Schafer, 1985). Levenson (1989) has taken psychoanalysts to task for being exclusively preoccupied with the former in connection with the exploration of “psychic reality” at the expense of recognizing the “actuality” of events inside and outside the psychoanalytic situation. The net result amounts to an institutionalized avoidance of actuality (an avoidance that may be linked with the avoidance of death as a real issue [Becker, 1973; Hoffman, 1979]). Levenson, however, appears to swing to the other extreme, denying the value, psychoanalytically,
of regarding those events as also representational or metaphoric and as intrinsically ambiguous (Hoffman, 1990). What I think is called for is an attitude that highlights the dialectic between the figurative or “as if” aspect of the analytic experience and its literal aspect. With regard to the analyst's involvement, the tension is between viewing it as creating opportunities for understanding in other terms, particularly in terms of the patient's externalization of internal conflict, and viewing it as important and consequential in its own right. It is important to recognize, moreover, that our participation is likely to be consequential before it is explicitly understood to the extent we might like.

More broadly, it is an aspect of normal human misery, after all, that we cannot wait to be “cured” of our neuroses before we are required to make choices that profoundly affect our lives and the lives of others. To believe that analytic therapists can create fully enlightened grounds for action in the context of their work with their patients is a pipe dream. Moreover, even after a conflict seems to have been explored extensively, how it should be resolved is often unclear. So I do not think we can wash our hands of responsibility at that juncture where neurotic suffering and normal human misery meet, because I see our intimate involvement with, and commitment to, our patients as requiring that we be partners with them in their struggles with often agonizing existential choices and predicaments.

**SOURCES OF THE ANALYST'S POWER**

Now I want to turn to the nature of the analyst's power and authority in the psychoanalytic situation. Psychoanalysis entails a complex combination of ritual and spontaneity in a unique form of human interaction. The methodical, ritual, relatively impersonal features of the process are associated most clearly with the maintenance of boundaries and the personal, spontaneous aspects with the cultivation of intimacy. But the two dimensions
of the process are in a dialectical relationship so that each can only be understood in the context of the other. Indeed, each is dependent on the other for its meaning. There can be no intimacy, of course, without boundaries in any relationship. The challenge is to try to conceptualize the particular nature of that dialectic as it is represented and played out in the psychoanalytic situation.

I am interested in exploring the idea that the analytic therapist is involved in the process as a kind of moral authority in the broad sense. There is an interesting precedent for this view in Freud. Along with the notion of the unobjectionable positive transference, Freud (1916) considered and struggled with the educative functions of the analyst in the context of what he called “after education.” He wrote of this aspect of the analyst's role:

... under the doctor's guidance [the patient] is asked to make the advance from the pleasure principle to the reality principle by which the mature human being is distinguished from the child. In this educative process, the doctor's clearer insight can hardly be said to play a decisive part; as a rule, he can only tell his patient what the latter's own reason can tell him. But it is not the same to know a thing in one's own mind and to hear it from someone outside. The doctor plays the part of this effective outsider; he makes use of the influence which one human being exercises over another. Or—recalling that it is the habit of psycho-analysis to replace what is derivative and etiolated by what is original and basic—let us say that the doctor, in his educative work, makes use of one of the components of love. In this work of after-education, he is probably doing no more than repeat the process which made education of any kind possible in the first instance. Side by side with the exigencies of life, love is the great educator; and it is by the love of those nearest him that the incomplete human being is induced to respect the decrees of necessity and to spare himself the punishment that follows any infringement of them (p. 312).

So Freud recognized that the analyst is in the position of a
particular kind of authority, an intimate, *loving* authority that has continuity with the kind of authority that parents have in the lives of their children. In this connection it is noteworthy that Freud (1927) thought that the analyst's social role could best be described as that of a "secular pastoral worker" (p. 255). Even though Freud thought of the exercise of authority by the analyst as limited primarily to persuading patients to come to terms with the "truth" about their internal and external worlds, he was hardly comfortable with this aspect of the analyst's function and warned of its dangers. In the *Outline* (1940) he expressed concern about crushing the patient's independence, insisting that "[i]n all his attempts at improving and educating the patient the analyst must respect his [the patient's] individuality" (p. 175). Nevertheless, it is clear that Freud recognized, perhaps grudgingly, that the analyst functions as more than just a neutral facilitator of the patient's own reflective rationality and insight. Indeed, in a late work, after discussing the psychological impact of "mystical practices," Freud (1933) went so far as to say that "it may be admitted that the therapeutic efforts of psycho-analysis have chosen a similar line of approach" (p. 80).

I think it is undeniable that the boundary between the analyst and the patient defines a relationship that is, in part, hierarchically organized. The psychoanalytic situation can be viewed as a unique kind of contemporary social institution in which one of the two people involved has a special kind of power to affect the other. The delicate integration of boundaries and intimacy, of ritualized asymmetry and mutuality (Aron, 1991; Burke, 1992; Hoffman, 1991; Modell, 1990) helps to promote the socially legitimized authority of the analyst's role. As a modality that has the ambitious aim of altering deeply entrenched patterns of self and object representations, psychoanalytic therapy has some of the properties of what the sociologists Berger and Luckmann (1967) call "secondary socialization." In this regard, psychoanalysis entails a type of "conversation" that in itself has the potential for a great deal of impact.
Different conversations can be compared in terms of the density of the reality they produce or maintain …. One may see one's lover only once a month, but the conversation then engaged in is of sufficient intensity to make up for its relative infrequency. Certain conversations may also be explicitly defined and legitimized as having privileged status—such as conversations with one's confessor, one's psychoanalyst, or a similar “authority” figure. The “authority” here lies in the cognitively and normatively superior status that is assigned to these conversations (p. 154).

When there is an attempt to radically alter an individual's “subjective reality,” analogous, perhaps, to what psychoanalysts would call “structural change,” what is necessary is a kind of “resocialization.” Of the latter the authors write the following:

These processes resemble [the] primary socialization [of childhood], because they have radically to reassign reality accents and, consequently, must replicate to a considerable degree the strongly affective identification with the socializing personnel that was characteristic of childhood ….

No radical transformation of subjective reality (including, of course, identity) is possible without such [affective] identification, which inevitably replicates childhood experiences of emotional dependency on significant others. These significant others are the guides into the new reality (p. 157).

The idea that psychoanalysis could bear any similarity to a process of resocialization is abhorrent to our sensibilities as analytic therapists. It smacks too much of brainwashing and too little of helping people become more aware of themselves and more able to realize their true potentials. And it is true that psychoanalysis puts a premium on skepticism and critical reflection, which distinguishes it from the other types of resocialization that Berger and Luckmann have in mind. However, I believe it is an overreaction both to the idea of brainwashing and to the dangers of unwitting and unexamined suggestion to deny that psychoanalysis entails a complex kind of concentrated social influence which partakes of some of the ingredients that Berger
and Luckmann attribute to “resocialization.” Not the least of these ingredients is a culturally sanctioned power that is invested in the analyst and that is sustained and cultivated in an ongoing way by the ritual features of the psychoanalytic process itself.

**DOMAINS OF THE ANALYST’S MORAL AUTHORITY**

I am thinking about two interrelated ways in which this power is likely to be (or perhaps is inevitably) utilized by the participants. One has to do with the affirmation of the patient's sense of self and worth as an experiencing subject and as an agent. The other has to do with accompanying the patient through, and in some measure becoming implicated in, the patient's choices as they emerge and are wrestled with over time. Some version of the first is more commonly accepted in the psychoanalytic community, implicit in various concepts. Relevant theorists are Strachey, Winnicott, Kohut, and others. The second is more controversial on its face. I think the two, although they can be distinguished conceptually, are inseparable in practice. Nevertheless, for discussion purposes, I will organize my remarks around affirmation in a relatively abstract sense, and then turn to the way in which its expression in practice implicates the analyst in the patient's choices and patterns of adaptation.³

Although there may be unconscious factors in the transference and the countertransference that interfere with the patient's ability either to elicit or to assimilate the analyst's affection and respect, I believe there is something to the simple idea that the analyst is an authority whose regard for the patient matters in a special way, one that we do not try to analyze away, nor could we, perhaps, even if we did try. In some cases it may take

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³ The two paragraphs that follow are taken largely from a previously published paper (Hoffman, 1994, pp. 199-200).
a lot of work to get to the point where that regard can be conveyed by the analyst and be received and integrated by the patient. But I doubt many of us have felt, as patients or as therapists, that the process, when it has been helpful, has not included that factor of affirmation (cf., Schafer, 1983, pp. 43-48). The likelihood of that happening in an authentic way is increased not only because the analyst is in a position conducive to eliciting a certain quality of regard but also because the patient is in an analogous position.

Regard for the analyst is fostered by the fact that the patient knows so much less about him or her than the analyst knows about the patient. The analyst is in a position that is likely to promote the most tolerant, understanding, and generous aspects of his or her personality. I think of “idealization” partly in interactional terms (as in “making the other more ideal”) because the analytic situation and often the patient actually do nourish some of the analyst's more “ideal” qualities as a person, what Schafer (1983) has referred to as the analyst's “second self.” Conversely, however, the analyst's regard for the patient is fostered by the fact that he or she knows so much about the patient, including the origins of the patient's difficulties and his or her struggles to deal with them. Moreover, of course, neither party has to live with the other or even engage the other outside of the circumscribed analytic situation so that each is afforded quite a bit of protection from the other's more difficult qualities.

Corresponding, again, with what several authors have discussed in terms of an interplay between the “principle of mutuality” and the “principle of asymmetry” (Modell, 1990; Aron, 1991; Hoffman, 1991; Burke, 1992), there is an ongoing dialectic between the patient's perception of the analyst as a person like himself or herself and the patient's perception of the analyst as a person with superior knowledge, wisdom, judgment, and power. Each way of viewing the analyst is very much colored by the other. Whichever is in the foreground, the other is always in the background. What the balance should be for any particular analytic dyad, at any particular moment or over time, is very difficult to
determine or control. Also, it must emerge from an authentic kind of participation by the analyst rather than from adherence to some technical formula. The patient may benefit, however, simply from his or her recognition of the sincerity of the analyst's struggle with the issue.

I believe that there is likely to be a special affirming power associated with the analyst's willingness to engage the patient in a way that is personally expressive and spontaneous. The source of that power is precisely in the ritualized asymmetry that promotes a view of the analyst as elevated in some sense and as beyond the patient's reach. In that context the analyst's emotional and personal availability can become a kind of magical gift that is assimilated in a manner that has continuity with (although it is hardly equivalent to) the way that the love of parents is assimilated in childhood. It might be argued that there is something magical associated with one person's winning the love of another no matter what the circumstances, and I would agree that what I am talking about is very closely related to the experience of love in other contexts. However, I am arguing that the analyst's personal involvement in the analytic situation has, potentially, a particular kind of concentrated power because it is embedded in a ritual in which the analyst is set up to be a special kind of authority.

I realize that these are uncomfortable ideas to entertain because they seem to imply an element of manipulation, just the kind that we imagine we are trying to undo through the analysis of transference. However, while such analysis might diminish

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4 The structure of the point I am making reminds me of Macalpine's in 1950 when she said, in effect: “Look, we have to face the fact that the analytic setting does not simply facilitate the flow of spontaneous associations. On the contrary, the setting generally creates a situation of loss and deprivation that induces regression.” Moreover, that is something, she said, that we don't tell our patients about, nor was she sure that we should. I am saying: “Let's not deny the power that we use to affect how our patients feel about themselves and how they conduct their lives, a power that does depend, in part, on the asymmetrical aspect of the relationship.” Unlike Macalpine, I think it would be best if this aspect of the process became an open subject for exploration in the analysis. Also, unlike Macalpine, I do not favor deliberately trying to induce a regressive transference neurosis by depriving the patient of an object relationship (cf., Lipton, 1977). I am advocating a more complex struggle within the dialectic of asymmetry and mutuality (Hoffman, 1992a, 1994).
or partially “deconstruct” the magical aspect of the analyst's role, I do not think it is likely that it would eliminate it entirely, which is probably fortunate. The very fact that we usually maintain the analytic frame even after termination to the extent that, for example, we do not become friends with or socialize with our patients in the usual sense, indicates that we want to preserve rather than undo the special kind of presence in our patients' lives that the analytic situation fosters. So those of us who are interested in developing more mutual and egalitarian relationships with our patients should not deny the extent to which we are drawing upon the ritualized asymmetry of the analytic situation to give that mutuality its power. The asymmetry makes our participation in the spirit of mutuality matter to our patients in an intensified way, one that helps to build or construct our patients' views of themselves as creative agents and as persons ultimately deserving of love.

Our responsibility becomes more daunting when we recognize that the process of affirmation is never content-free. I do not think it is possible to locate and respond to a pure potentiality for experience and choice within the patient. Our affirmative attitude inevitably gravitates toward some of the patient's potentials at the expense of others. In that sense, affirmation of a patient's sense of self and participation in his or her moments or patterns of choice become inseparable. The context of affirmation is always one in which our patients are in the midst of doing or saying something or just being a certain way or set of ways. If we must have responsibility for affecting a patient's sense of self and worth, we might wish that, with regard to content, the patient's experience would be the exclusive governing factor in the interaction. If we are there as empathic self-objects (Kohut), or as responders to the spontaneous gestures of our patients germinal or half-buried true selves (Winnicott),
then we ourselves as people with our own individual dispositions and values can disappear just as effectively as we could behind the mantle of scientific objectivity in the classical model. But affective attunement and empathic responsiveness no less than traditional interpretation are colored by each therapist's cultural, theoretical, and personal bias. Whatever the commonalities, there are undoubtedly nuances in the nature of affective attunement that vary from one culture to another and from one parent to another or one therapist to another within the same culture (see Cushman, 1991; Seligman, 1990). I am not for a moment questioning that there is a difference between impinging on our patients in an intrusive way and leaving room for their relatively spontaneous initiatives. But no matter how far we go in the direction of responsivity, we never reach a point where our own personalities disappear from the field.

I am anticipating that some might argue that perfect empathy and attunement, like perfect objectivity, are merely ideals to strive for, with the understanding that we are always falling short of them despite our best efforts. My reply is that I do not think it is good to set up intrinsically irrational ideals that do violence to human nature. Aspiring to walk on water and striving to be able to do that are bound to interfere with learning to swim. Such a standard of locomotion is no less wrongheaded if we humbly “admit” that, since nobody is “perfect,” those attempting to walk will surely get wet. The ideals of accurate empathy and perfect affective attunement, like the ideal of perfect neutrality, encourage the development of inappropriate ego ideals which in turn promote defensive illusions about what we have been able to accomplish, along with misleading acknowledgments of our “imperfection.”

All of that distracts us from the more relevant issue which is to consider, not whether, but how we have been personally involved with our patients. Also, such reflection does not erase our participation and its effects. Talking about our suggestive influence may liberate the patient from some of its unconsciously controlling power, but we are kidding ourselves if we think we have thereby managed
to remove ourselves from the field or even that we have managed to restrict our influence to what is in accord with the valuing in psychoanalysis of consciousness and individual freedom. Indeed, the very way in which we analyze one “suggestion” is likely to carry another with it that is unknown. This is not to say that the patient is simply putty in the analyst's hands. On the contrary, it is precisely respect for the patient's agency that opens the door to overcoming our phobic attitude toward our own personal influence on our patients' lives. But let me hasten to add that after we have overcome that phobia, there is plenty left in the realm of relatively normal anxiety that is warranted in light of the unique nature of our responsibility as participants in the patient's struggle for integration and self-definition.

With regard to cultural bias, Cushman (1995) has contributed a major work exploring, both historically and clinically, the way in which psychoanalytic therapy tends uncritically to adopt and support the values of competitive, materialistic individualism even though it has the potential to be a more constructively critical institution. I agree with Cushman's thesis that psychoanalysis is inevitably a moral enterprise and that it behooves the analyst to include, within the analytic work itself, scrutiny of his or her own passive conformity to prevailing social expectations regarding what constitutes the good life. Cushman is loathe, however, to search for possible universals underlying the activities and roles of “healing” figures in various cultures and subcultures, a project that seems quite useful to me, and one which is actually implicit in Cushman's own approach despite his emphasis on cultural differences. He writes:

Each era has a predominant configuration of the self, a particular foundational set of beliefs about what it means to be human …. These selves and roles are not interchangeable or equivalent. Each embodies a kind of unique and local truth that should not be reduced to a universal law, because such reductions inevitably depend on a particular cultural frame of reference, which in turn inevitably involves an ideological agenda (p. 3).  

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Granting the factor of cultural relativity, is Cushman not pointing also to the universal need for some kind of belief system and are there not moral authorities in every culture who provide a special kind of support to whatever the local belief system might be? Put another way, is not the claim that social reality is socially constructed one that Cushman believes is true transculturally and transhistorically, amounting, therefore, to a “universal law”? It may be that, in keeping with our postmodern sensibility, this perspective emerges specifically in our era, but the origin of the view has no bearing on the truth value that is being claimed for it. Cushman, despite his stated aversion to universalizing, writes the following regarding the human condition:

There is something in the very nature of being human that makes it extremely difficult to differentiate what we are from what we construct, or what we can be from what our horizon permits us to be. We construct the social world in such a way so that we can consider it, experience it, as reality itself—the one, true, concrete truth. To do otherwise would be to open up the existential abyss for us, to force us to confront our own lacks, absences, and emptiness, to challenge the taken-for-granted power relations, economic privileges, and status hierarchy of our era, and to acknowledge the relational rules, alliances, and secrets of our family of origin. For various reasons, an awareness of the constructed nature of our world appears to be too difficult to acknowledge and too frightening to live with (p. 309, italics added).

And yet the psychotherapist is called upon to question the status quo, and to open thereby that dreaded “existential abyss.” Cushman says, “It is precisely this conspiring, this unknowing, embodied collusion that psychotherapy is designed to reveal and undo” (p. 310). It is one thing, however, to expose hidden values and biases and quite another to reject them in favor of specific alternative ways of being. Psychoanalytic skepticism itself, potentially informed and shaped by the critical spirit of postmodernism, ensures a questioning attitude toward explicit and implicit
value systems, old and new. It casts doubt upon the moral authority of the analyst even as aspects of analytic ritual promote its influence. The authority that endures can only be an ironic one, given the extent to which it is challenged. When we are aware of “the constructed nature of our world,” we can no longer live in it with the same faith and in the same taken-for-granted way that was open to us without that awareness. Indeed, the one absolute that may survive such exposure is the value of that very awareness and, with it, the value of critical reflection upon one's world and oneself.

“SESSIONS” WITHIN SESSIONS

Now I would like to go back to the anecdote from the TV program, the episode of Sessions. I have something more to add to the story. It so happens that I do not get cable TV in my home and that the way that I learned about Sessions was from a patient of mine who watched it regularly and thought I would enjoy it. He said he could tape a couple of episodes for me if I was interested. I said I was, and he brought them in. Although once I took the tape I felt I should see the program, I did not feel undue pressure from the patient who is not at all demanding in his manner. Actually, I thought of it as an opportunity to share an experience with him that was of mutual interest. It is the sort of thing that I will do sometimes: see a movie a patient recommends, read something he or she suggests, and so on. I am especially likely to do it if I feel that it might further the process, that it is in keeping with my own interests, and that it does not result in my feeling overextended.

Of course, my conscious experience in this respect is not always reliable. It is always possible that a seemingly “conflict-free” response to a patient's appeals entails repression of the conflictual elements in both parties. The patient's regressively devouring impulse may be denied, for example, along with the analyst's impulse to retaliate. Or the patient may be identified with a demanding, intrusive, or assaultive parent while the analyst
may be in the position of the child who is rationalizing his or her compliance (cf., Frederickson, 1990; Tower, 1956). When the analyst can detect signs of being caught in the “grip” of such a transference-countertransference field (D. B. Stern, 1991), he or she can begin the work of extricating him- or herself and the patient from it through reflection, interpretation, “negotiation,” and other kinds of actions (Ehrenberg, 1992; Gill, 1982, 1994; Hoffman, 1983, 1992a, 1992b, 1994; Mitchell, 1988, 1993; Pizer, 1992; Racker, 1968; D. B. Stern, 1989; Tansey and Burke, 1989). The relationship between repetition of pathological aspects of the past and relatively new experience is usually highly complex and paradoxical. In fact, it is generally useful to view their relationship as dialectical, that is, each not only serves as ground for the other but is actually on the brink of evolving into the other (Ghent, 1992; Hoffman, 1992a, 1994).

The example I am presenting here is relatively uncomplicated, however, in that, so far as I was aware at the time (and have been since), the work was going on in the context of a rather strong sense of relatively unobjectionable positive transference and countertransference. There was a feeling that the analytic relationship contrasted with the pathogenic aspects of the past in a rather straightforward way. While the prevalence of a manifestly benign atmosphere can be grounds for suspecting something latently malignant, I do not feel it is necessary to arrange the analytic situation to induce the emergence of the latter. Macalpine's (1950) conceptualization of the analytic process in terms of a systematic induction of a regressive transference neurosis was based upon the assumption that the patient's pathogenic desires could be reduced to obsolete wishes that had to be renounced. We currently have a much broader conception of the nature of those desires which have come to encompass legitimate developmental needs. Now, if anything, we are in

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5 In this regard, Steven Stern (1994) draws a useful distinction between “the repeated relationship” (in “Type I transference”) and “the needed relationship” (in “Type II transference”).

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danger of the opposite mistake, which is to reduce the patient's desires to legitimate needs and to omit consideration of less legitimate wishes (Mitchell, 1988). Either reduction can lead to a mechanical, objectivistic approach, one lacking spontaneity and personal expressiveness.

Components of an optimal analytic attitude include: recognition of the dialectical relationship between the authority enhancing aspects of analytic ritual and the elements of mutuality and spontaneity within the personal side of the relationship; a perspective in which the patient's experience is seen as involving a complex, fluctuating hierarchical arrangement of needs and wishes, the quality, intensity, and rank order of which are partially dependent on the nature of the analyst's participation (Hoffman, 1987; Mitchell, 1993); recognition of the dialectical and often paradoxical relationship between repetition and new experience in the psychoanalytic process (Ghent, 1992; Hoffman, 1992a, 1994; Pizer, 1992); and appreciation of the fact that the analyst is always in a position of some uncertainty as to the nature of what has emerged in the patient and in himself or herself as wellsprings for action.

Ultimately, there is no escape from the responsibility that falls to the analyst to act with as much wisdom as possible even while recognizing the action's subjective foundation. Sometimes, the sense of uncertainty is there in principle, but what is in the foreground is a sense of conviction about how a particular line of thought or a particular kind of responsiveness might help to develop the relationship in a creative and authentic way (Bader, 1995; Hoffman, 1992b). Such was the case in the example I have begun to report.

So to return to the story, in this instance I was pleased to accept the videotape that the patient brought in. Watching the program at home was an experience that was embedded in the analytic process, although outside of its customary boundaries. I will not go into detail about the case, except to say that the patient is the son of Holocaust survivors who raised him in a manner that was very austere, almost as though they were identified
with their persecutors and he and his siblings were their prisoners. In his whole life he could not recall ever getting a toy from either parent. Room and board were provided but there were virtually no overt demonstrations of affection. He said his parents never played with him. In addition, he was raised in an ultraorthodox religious manner. His parents, especially his father, were extremely strict about observing Jewish law. Therefore, I experienced the sharing of the tape, immediately, in the context of this patient's life, as a form of playing (Ehrenberg, 1992; Feinsilver, 1989; Winnicott, 1971) that violated the orthodox observance of psychoanalytic rules in a way that I thought was good.

Now we cannot omit from what I felt about all of this the fact that I also attended a parochial grade school and high school, although a much more liberal and modern one than what this patient went through. Nevertheless, like the patient, I broke from the tradition that I was raised in and now bear an ambivalent relation to it. Perhaps, not coincidentally, I have also broken from certain aspects of psychoanalytic orthodoxy. How could those experiences not color my experience of this patient's efforts to escape what I thought of as the bondage of his austere upbringing and, more immediately, the constraints of the usual boundaries of the analysis?

So I watched the tape. I enjoyed it a lot and told the patient so in the next session. We chatted a bit about various aspects of the program, some of which were, and some of which were not, as far as I could tell, of any special interest analytically. Incidentally, that ostensibly “inconsequential” part from the point of view of the analytic work was actually a very important part of the experience because it was spontaneous and informal and not explicitly analyzed. If you try to analyze everything, even all aspects of possible enactments, you are bound to suck the life out of the experience. Indeed, why the analyst and the patient would feel compelled to do that would be the next thing that probably should be analyzed.

In this instance we did touch on various aspects of the program.
We talked about the analyst's specific suggestion with regard to the father, and together we mulled over the question of whether there was any way the patient could approach his father that might create the opportunity for a breakthrough in their relationship. The patient did not think so, and I felt he was right. He said he was moved when the son and the father hugged at the end. I said I had been moved, too, but that I understood that his feelings had special poignancy in light of the seemingly impenetrable barriers between himself and his own father.

With regard to the analyst’s transparent disclaimer, “just a thought,” it has become a standing joke between us so that whenever I notice that I am tilting one way or another on some dilemma the patient is struggling with, either he or I will comment, “just a thought, of course.” With regard to the sharing of the tape, I said something like, “Well, he walks around a lot in the office but I didn't see him borrowing any of the patient's videotapes, so maybe I win in the competition for who is freer and more flexible.” The patient laughed. It certainly is part of the atmosphere that we enjoy each other's sense of humor. An important point here is that I feel that my borrowing the tape was embedded in an atmosphere of mutual understanding as to one of its probable meanings in the context of the patient's life story so that it seemed to go without saying that the interaction contrasted with any the patient could ever have had with his parents. Some personal moments like that are pre-analyzed or “pre-shrunken,” and it is sometimes not worth laboriously searching anew for their unspoken or unconscious meanings because then you risk spoiling the element of spontaneity in them. On the other hand, if there are subsequent dreams or other associations

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6 Joking remarks of this sort are often implicitly interpretive of issues in the transference and the countertransference. In this instance, among other things, the comment touches on the patient's wish that the analyst be flexible, the possibility that the patient is intending to evoke some competitive feeling in him, and the element of competitiveness that the countertransference actually includes at a conscious level.
that seem to allude to the unconventional interaction, it would be important, of course, to try to interpret them in light of that event.

To locate this vignette further in relation to the central issues I am considering, my borrowing the tape and sharing the experience of viewing the program and discussing it later were all actions that were expressions of my special rapport with this patient. I admired his sensitivity, his humor, his courage in breaking from his anhedonic family's restrictive codes of conduct, and his active search for experiences of pleasure with other people. I also trusted this patient, in that I did not feel that his making this request would open the floodgates for all kinds of demands. I felt confident that he respected my boundaries and was not going to make a habit of asking that I violate them. At the same time the contents of the session in the TV program and of the actual analytic hour bore on the patient's hunger for an affective connection with a parental figure. The key here is that my closeness with this patient and my enjoyment in working with him on what Ehrenberg (1992) calls “the intimate edge” drew special power from the fact that, after all, I was also his analyst. As his analyst I did not have to participate with him in this way. And as his analyst I had already acquired some of the regard and power that is inherent in the role, at least as a very strong potentiality.

Finally, the expressions of recognition and attunement and the affective tone that accompanied them included much that came from my own personality and history. I could have been an analyst who was either seriously committed to the tradition in which the patient was raised or who practiced psychoanalysis in a more traditional way, and I doubt that the same kind of interaction would have occurred. It is quite possible that if the approach were more traditional, the patient never would have suggested that the analyst borrow the tape to begin with, since the atmosphere might not have been conducive to such a proposal. Instead, the patient may have experienced more grief about the absence of a warm, playful, affectionate environment.
in the analysis, repeating, but also usefully bringing into focus, the deprivations of his childhood.

Similarly, surely something else would have happened with an analyst who was more valuing of traditional religious practices. As different as that might have been, would it necessarily have been any less empathic or attuned to this patient's needs? For example, perhaps in that setting and in that company what would have gained more force would have been the patient's missing the orthodox community that he had moved away from, and a stronger although still conflictual wish to return to it. The patient and I certainly talked about that side of his conflict but without the same conviction that was mobilized on the other side. It would be comforting to think that what emerged with me was something closer to what Winnicott would call the “true self” and that what would have emerged with this other, hypothetical therapist would have been something more like the “false,” “compliant self.” But I doubt that the difference is that cut and dried.

The patient's experience always contains a variety of potentials, including multiple potential “selves” or aspects of self (see Mitchell, 1993). Which of those potentials develops further and is strengthened might have something to do with who we (the therapists) are as people, reflected in what we respond to, with what affect, and with what degree of conviction. Again, whatever our orientation in other respects, we have to recognize that we are intimately involved in our patients' struggles to make better lives for themselves, and we cannot ignore our own vision of the better life in our participation in those struggles.7

7 I realize that there are different kinds of values associated with a sense of freedom and playfulness, on the one hand, and a wish to break away from a specific orthodox belief system, on the other. The former is a more “universal” value, or at least one about which there is more consensus in our culture. The latter is grounded more in assumptions that apply to a particular subculture or individual. It might be argued that it is acceptable for analysts to be biased in favor of the more universal values but that they have no business exercising influence with respect to the more individual issues. In practice, however, I believe that even with respect to the more individual matters, analysts are more involved than is often recognized. Moreover, the more commonly accepted values may be tied to particular cultural practices and beliefs that also warrant critical examination (Cushman, 1991, 1995; Grey, 1993; Seligman, 1990).
There are occasions when the patient, in order better to exercise his or her own judgment, deserves to know something about the personal factors that we sense may be affecting the nature of our participation. I shared quite a bit with the patient I have discussed regarding my background and my own attitudes and conflicts with regard to some of the issues that he was dealing with. Sometimes, having those things on the table gives the patient the chance to see the relativity of the analyst's point of view to the analyst's own experience and history. What should or should not be revealed is a difficult and personal matter. My point is that in a constructivist view of the process we have the responsibility to come to terms with, and find ways to manage, our personal influence without the protections that are afforded by a model of scientific inquiry into “the facts” of the patient's experience.

FROM SOLITARY REFLECTION TO RELATIONAL STRUGGLE

If we think of the history of our sense of the analytic process, we can trace a movement—one that is decidedly nonlinear—from Freud's solitary reflection on his own dreams which sets up self-analysis as the ideal, to the detached presence of the analyst as a scientific observer and facilitator of the transference and its interpretation, to a view of the analyst as responsive in a therapeutically corrective way to the patient's needs and deficits, to an appreciation of the usefulness of countertransference in the process, to an understanding that the analyst's interpretations do not simply map on to a prestructured reality but rather contribute something to the construction of that reality, to a recognition of the culturally relative and ironic aspects of the analyst's
authority, to an appreciation of the full extent and implications of our personal involvement with our patients as they struggle to make sense of and to modify their ways of experiencing and constructing their worlds. Stated succinctly, and summarizing the movement from the beginning until now, we have traversed the distance from analysis as solitary reflection to analysis as relational struggle. In the latter, against the backdrop of the ritualized asymmetry of the psychoanalytic situation from which we draw special moral power, we participate as intimate partners with our patients as they wrestle with conflict and as they choose from among, and struggle to realize, their multiple potentials for intimacy and autonomy, for identification and individuality, for work and play, and for continuity and change.

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