The Analyst's Knowledge and Authority: a Critique of the "New View" in Psychoanalysis

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THE ANALYST'S KNOWLEDGE AND AUTHORITY: A CRITIQUE OF THE "NEW VIEW" IN PSYCHOANALYSIS

A critical assessment is presented of positions recently taken by Mitchell and Renik, who are taken as representatives of a "new view" in psychoanalysis. One article by Mitchell and two by Renik are examined as paradigmatic of certain ways of construing the nature of mind, the analyst's knowledge and authority, and the analytic process that are unduly influenced by the postmodern turn in psychoanalysis. Although "new view" theorists have made valid criticisms of traditional psychoanalytic theory and practice, they wind up taking untenable positions. Specifically called into question are their views on the relation between language and interpretation, on the one hand, and the mental contents of the patient on the other. A disjunction is noted between their discussion of clinical material and their conceptual stance, and their idiosyncratic redefinitions of truth and objectivity are criticized. Finally, a "humble realism" is suggested as the most appropriate philosophical position for psychoanalysts to adopt.

A number of influential articles have recently appeared that present fundamental criticisms of traditional conceptions of the psychoanalytic situation and of the basis for the analyst's knowledge

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and authority, and that propose replacing those conceptions with radically different ideas. The articles we take as paradigmatic of what we call the "new view," and on which we primarily focus, are one by Stephen Mitchell (1998) and two by Owen Renik (1996,1998a).

We regard these articles as paradigmatic for a number of reasons: Mitchell has been one of the most articulate and influential spokespersons for a relational position that has represented a serious challenge to traditional psychoanalytic views. In the 1998 paper that we discuss here, Mitchell's relational view is extended to formulate a conception of mind, of the analytic situation, and of the nature of the analyst's knowledge and authority that resonates with, and perhaps most clearly expresses, the postmodern turn in psychoanalysis and psychotherapy.[1] Renik's papers pose a similar challenge in their focus on these issues and on the nature of the analyst's subjectivity and objectivity. Indeed, the very title of Renik's edited book (1998) is virtually identical to that of Mitchell's paper—in both, the keywords are *knowledge* and *authority.* By subjecting Mitchell's and Renik's papers to scrutiny we attempt to critique the general view of which they are representative.

In challenging and criticizing traditional, or classical, psychoanalysis, "new view" theorists have presented some legitimate and important criticisms. For example, along with others, they have rejected the notion of the analyst as a blank screen. They have also justifiably criticized a therapeutic stance in which analytic neutrality had come to mean aloofness and stodginess (Holzman 1985). New view theorists have correctly insisted that the analytic encounter is a two-person situation in which the participants inevitably interact, emit cues, and influence each other. They have thus sensibly concluded that the patient's transference reactions are often best understood not as a simple distortion, or as a simple projection onto a blank screen, but rather as plausible

[1]This article was written before Stephen Mitchell's tragic and untimely death. We understand that he was to be given an opportunity to reply and deeply regret that he cannot. His remarkably challenging ideas always forced one to think through fundamental issues and assumptions. This article is but one instance of how his ideas and formulations forced one to examine such basic issues as one's conception of mind and the nature of the analyst's knowledge and authority. Our article does not deal with, nor does it question, his seminal contributions to a relational conception of psychoanalysis. Those contributions have deservedly had an enormous impact on our field. Though in this paper we are critical of some of his ideas, our criticisms should be viewed as the product of treating his ideas with the seriousness they deserve. Again, we wish he could have responded with the vigor and intensity with which he carried out all his work.

interpretations of the analyst's behavior (Gill 1982, 1994). This emphasis on the patient-analyst interaction has made us more sensitive to the influence of the analyst's biases and idiosyncratic history on the analyst's understanding of the patient, on the material on which the analyst chooses to focus, and on the reactions the analyst may elicit in the patient (Smith 1999). New view theorists have argued against the naive belief that the possession of psychoanalytic theory gives the analyst virtually infallible access to the Truth about the patient, and they have rejected what they take to be the implicit claim of classical theory that there is a singular canonical interpretation of the patient's material. These and other substantive criticisms of classical theory have arguably been beneficial and will not be the focus of our discussion.

New view theorists do not simply argue these substantive points on their merits; they attempt to justify their critical conclusions by invoking a set of philosophical doctrines about the nature of mind, the relation between subjectivity and objectivity, the role of uncovering (as against constructing) meaning in psychoanalysis, and the nature of the analyst's knowledge and authority. These philosophical doctrines have profound implications that go far beyond the justification of substantive concerns about the analytic situation. It is these philosophical doctrines that will be the target of our examination.

The central philosophical position of new view theorists concerning the nature of mind is that it is in its entirety interpretively constructed in the context of interpersonal interaction. Because mind is accorded no factuality independent of interpretive construction, nothing is held to be uncovered or discovered in the psychoanalytic process. Rather, new meaning systems, new perspectives, and new narratives are constructed and negotiated. According to this view, mind is not preorganized but rather awaits organization and the articulation of mental contents through interpersonal interaction. Interpretations need be constrained not by the degree to which they "tally with what is real in [the patient]" (Freud 1916–1917, p. 452), but only to the degree to which they presumably contribute to personal happiness and are "helpful in generating a sense of personal meaning and value" (Mitchell 1998, p. 26).

It should be emphasized that one can accept the substantive criticisms of the new view without adopting its philosophical conceptions. For example, arrogance, aloofness, a dogmatic belief in one Truth about the patient, or a failure to appreciate the central importance of the

ongoing patient-analyst interaction can be criticized without invoking a new philosophy of mind. Although we are sympathetic to many of these criticisms, it is not our intention here to argue for or against them. Rather, we are concerned with the attempt of new view theorists to derive their conclusions directly from their philosophical positions. We believe that the validity of these positions and their implications for psychoanalysis have not adequately been examined.

There are clear parallels between the new view literature and postmodernist challenges to the "Enlightenment vision," including the fundamental thesis that "our statements are typically true or false depending on whether they correspond to how things are, that is, to facts of the world" (Searle 1998, p. 10). This thesis, we maintain, holds as much for statements about inner psychic reality as for statements about external reality. There are "facts of the world" about the contents of the mind, and there are statements about the mind that are probabilistically true or false to the degree that they correspond to "how things are"—that is, to the degree that they "tally with what is real in [the patient]." The new view theorists' implicit rejection of this thesis as applied to statements about inner psychic reality is based, we will try to show, on confused and invalid arguments.

The clearest expression of the "Enlightenment vision" in psychoanalysis is found in classical theory. In linking the "cornerstone" concept of repression—the essence of which is the failure to acknowledge the truth about oneself—to pathology, and in linking the lifting of repression—the essence of which is increased self-knowledge—to cure, Freudian theory staked its claims to cure on the assumption that there are real contents in the psyche that can be discovered, or at least approximated, via psychoanalysis. Thus, for Freud, self-knowledge was not only a Socratic virtue but a clinical necessity. This basic idea remained a constant for Freud, whether hypnosis was employed to uncover traumatic memories or interpretation was used to uncover unconscious wishes and defenses. Freud clearly thought of this assumption as the sine qua non of the psychoanalytic enterprise, a constitutive principle essential to the whole idea of analyzing the mind. This is the main reason why the notion that the analyst simply suggests meanings to the patient was anathema to Freud. Indeed, when Fliess accused him of suggesting ideas to his patients, Freud (1954) retorted, "you take sides against me and tell me that the 'thought reader merely reads his own thoughts into other people', which deprives my work of all its value" (p. 336).

Psychoanalysis has of course undergone many theoretical and technical changes since Freud, and many of Freud's cherished doctrines have proved inadequate. But until recently, all psychoanalytic approaches have shared with Freud the core philosophical belief that at least to some degree, or in some ways, there is a truth about the contents of the patient's mind that it is the analyst's task to discover and understand, however approximately. Thus, central to psychoanalysis, from Freud onward, is the belief that psychoanalytic interpretations do not simply constitute suggestion but correspond, at least to some degree, to the inner reality of the patient. In attempting to justify their criticisms of certain aspects of classical theory, new view theorists take philosophical positions that entail a dismantling of this core assumption. Their philosophical positions therefore warrant careful scrutiny to determine whether analysts are justified in adopting them.

Our main thesis is that new view theorists, in attempting to justify their critique of classical theory, have taken philosophical positions that are untenable, create at least as many difficulties as they are intended to resolve, and undermine assumptions essential to psychoanalysis. We also maintain that these positions are unnecessary to sustain the legitimate criticisms of psychoanalysis advanced by new view theorists. We show that even they are uncomfortable with a philosophical position that precludes any attempt to uncover truths about mental contents. This discomfort is reflected both in the disjunction between their conceptual stance and the clinical material they present, and in their tortured redefinitions of truth and objectivity. We conclude that a fruitful philosophical position for psychoanalysis is a "humble realism" in which one recognizes the uncertainty of psychoanalytic inference but nonetheless is governed by the ideal that interpretation and understanding attempt to "tally with what is real in [the patient]."

MITCHELL'S CONCEPTION OF MIND

We begin with Mitchell's "The Analyst's Knowledge and Authority" (1998). As noted, Mitchell wants to reject what he believes is the typical classical analyst's claim that the analyst, as a neutral, objective observer armed with psychoanalytic theory, possesses "a singular scientific knowledge and authority vis-à-vis the patient's mind" (p. 16). This criticism could be mistaken for the strictures of critics who

demand a more solid evidential basis for what they view as inflated claims to knowledge and authority. It could be mistaken also as a call for greater modesty and a tempering of unrealistic and sometimes arrogant claims. Mitchell's criticisms, however, come from a very different direction. His position, rather, is that (1) neither analyst nor patient uncovers or discovers anything in the patient's mind; and (2) the only expertise the analyst has is in "meaning-making, self-reflection, and the organization and reorganization of experience" (p. 2).

At the core of Mitchell's dispute with traditional views of psychoanalytic knowledge is his conception of the mind as constructed rather than uncovered. We say "rather than" because Mitchell presents constructing and uncovering as mutually exclusive. According to Mitchell, "there are clearly no discernible processes corresponding to the phrase 'in the patient's mind' for either the patient or the analyst to be right or wrong about" (p. 16). The analyst does not discover or uncover any mental content "that has tangible existence" (p. 17). Rather, "mind is understood only through the process of interpretive construction" (p. 16).

Hence, Mitchell's philosophical rationale raises issues that go deeper than his substantive concerns regarding the classical analyst's purported arrogance, misplaced certainty, and unearned authority. One can temper these attitudes and continue to believe that there is something in the patient's mind to be uncovered. But Mitchell appears to believe that the idea that one can ever uncover anything in the patient's mind, rather than "interpretively constructing" it, is a misguided and mistaken view.

If by saying that one "interpretively constructs" another's mind Mitchell means simply that one *infers* that person's mental states, rather than having direct access to them, he is doubtless correct. That idea is neither controversial nor new. One certainly does not have direct, unmediated access to another's mind. (What can it even mean to say one does? Would it amount to a claim of telepathic access?) If by saying that there is no "singularly correct canonical interpretation" of another's mind he means that many inferences, not all of them compatible, are possible, particularly with regard to the kind of complex mental states in which analysts are interested, then he is also right. If, for example, he means to assert that seemingly warranted inferences can, because based on inadequate clinical evidence, turn out false, or that two different analysts might draw incompatible conclusions on the

basis of the same evidence and that thus at least one would of necessity be false, he is again correct. Or, if he means that there are many different aspects of the patient's mental reality that can be emphasized in an interpretation, or over the course of an analysis, and thus that there are many different correct interpretations and analyses possible on the basis of the same evidence (although all correspond to parts of one overall mental reality and thus are true), then he is also correct.

However, Mitchell wants to assert a good deal more than simply that one infers what is going on in another's mind and that many inferences about what is going on are possible. When Mitchell writes that one "interpretively constructs" another's mind, he means to claim that it is a mistake to think that mental states exist apart from one's "interpretive construction" and that they are therefore not the kind of thing one can be right or wrong about. Only this construal of "interpretive construction" would lead one to the extreme conclusion that "there are no clearly discernible processes corresponding to the phrase 'in the patient's mind' for either the patient or the analyst to be right or wrong about" (p. 16). If "interpretive construction" simply meant inference, no such conclusion would be warranted.

That by "interpretive construction" Mitchell does not intend simply inference is indicated also by his assertion that the former applies equally well to one's own mind as to another's and to both conscious and unconscious experience. As Mitchell puts it, "Consciousness comes into being through acts of construction either by others or, through self-reflection, by oneself" (p. 16). Given this position, if by "interpretive construction" Mitchell means inference, he would have to say that just as one infers what is going on in another person's mind, so equally does one normally infer one's own conscious experience—a conclusion that is patently false. For although conscious experience may be the product of "silent" constructive processes (see, e.g., Neisser 1967, 1976), one cannot equate the inferences involved in understanding another's mind and the "silent" constructive processes involved in generating one's own conscious experience. Whereas one may infer what is going on (consciously or unconsciously) in another's mind, one normally does not infer one's own conscious experiences. One simply *has* them—even if "silent" constructive processes underlie them. However complex the "silent" constructive processes that produce them, conscious experiences have a directness and immediacy, whereas knowing what is going on

in another's mind is always and necessarily indirect and inferential. So Mitchell's claim that we construct conscious experience is not consistent with the notion that what he means by "interpretive construction" is simply inference.

As for the claim that mental processes are not "clearly discernible," the fact that the unconscious mental processes in which analysts are interested are not transparent but rather opaque is the very reason interpretation or inferences are required. That necessity, of course, does not imply that one cannot be right or wrong about one's interpretations and inferences. To put it more probabilistically, some interpretations and inferences are more likely to be right and others wrong.

In short, Mitchell strongly suggests that in his view another's mind is not inferred, but rather is *constituted* by interpretive construction. If this is the case, it follows that "there are no discernible processes corresponding to the phrase 'in the patient's mind' for either the patient or the analyst to be right or wrong about" (p. 16) and that there is no singular canonical interpretation of another's mind. But it follows also that there can be no multiplicity of correct interpretations. That is so because the issue of correct—or even plausible—interpretations applies only if one believes it possible to evaluate the degree to which an interpretation corresponds to something independent of that interpretation—not when the interpretation *constitutes* what is being interpreted.

In the sections that follow we will address the main grounds given by new view theorists for maintaining that psychoanalysis consists of interpretive constructions rather than the uncovering of truths about the patient's mind. These are (1) the irreducible subjectivity of the analyst's judgments (here we will focus primarily on Renik's views); (2) the nonfactuality of the mental—the claim that there are no facts about the mind to be discovered; (3) the vague and unformulated prelinguistic status of many mental contents, which implies that language and interpretation actually create new experiences rather than describe what exists; and (4) the idea that although mind preexists it awaits organization through the patient-analyst interaction.

RENIK ON WHOSE MIND IS BEING ADDRESSED AND UNDERSTOOD

Like Mitchell, Renik (1993, 1996, 1998a) dichotomizes between uncovering and discovering, on the one hand, and providing "alternative

perspectives" on the other—his version of "interpretive construction." He then opts for the latter as the primary task of analysis, supporting his position by focusing on the "irreducible subjectivity" of the analyst's judgment. Indeed, Renik (1996) presents what might be considered a solipsistic variant of Mitchell's position. He considers the traditional claims that "the analyst addresses the patient's, rather than the analyst's own psychic reality" (p. 509) and that "the patient is not given the analyst's own idiosyncratic views, but rather the analyst finds the patient's views" (p. 509). He argues that these claims "are essentially versions of [an untenable] analytic neutrality, in that they maintain the notion that the analyst's analytic activity does not consist essentially of communicating his or her personal judgments" (p. 509).

There is a confusion in the opposition Renik sets up between the analyst's personal judgments and idiosyncratic views, on the one hand, and attempts to understand the patient's psychic reality on the other. However personal and idiosyncratic the analyst's judgments and views may be, they are judgments and views *about the patient's psychic reality.* They are, indeed, attempts to "find the patient's views." What else would they be? Like Mitchell, Renik wants, justifiably, to oppose the idea that the analyst is a perfectly objective observer who has direct access to the patient's psychic reality and communicates it to him or her. One can, however, recognize the untenability of this idea and nevertheless recognize that the analyst is attempting, however imperfectly and idiosyncratically, to understand and address the patient's psychic reality and to "find the patient's views" rather than his or her own psychic reality. And when the analyst does address his or her psychic reality in the treatment situation—as, for example, when scrutinizing countertransference reactions—it is in the service of furthering understanding of the patient's psychic reality. In the context of treatment, what other purpose would the analyst have in addressing his or her own psychic reality? The analyst's understanding of the patient is of course filtered through subjective experience—that is, the analyst's psychic reality—which may be what Renik is intending to emphasize. But the primary task of the analyst is to understand and address the patient's psychic reality, not his or her own. This would seem axiomatic in all analytic work and has little to do with the issue of analytic neutrality. The confusion arises when Renik equates neutrality with the claim that the analyst is trying to understand and address the patient's psychic reality rather than his or her own. One can be intensely involved and

nonneutral with a patient and can form, as well as communicate, all sorts of personal judgments regarding the patient's life and yet still try to address his or her psychic reality. Indeed, one's personal judgments regarding the patient are, one would hope, based on one's assessment of his or her psychic reality.

Renik seems to think that because the analyst's understanding and experience of the patient are irreducibly subjective (Renik 1993), it is not possible for the analyst to attempt as objective and "disinterested" an understanding of the patient as possible. According to Renik (1993), the analyst's claim of "disinterested understanding" accords him or her "undeserved authority" (p. 508). But "disinterested understanding" of another does not mean that one cannot make personal judgments regarding how that person has gone about his or her life or even what is in his or her best interests. "Disinterested understanding" of another means that one's understanding is in the service of what one takes to be that person's—rather than one's own—interest and benefit. Of course, personal judgments are involved in such understanding. How could they not be? But those personal judgments are based on one's understanding of that person's needs, wishes, conflicts, fears, and so on.

As for the "irreducible subjectivity" of the analyst, experience of any kind—whether of another person or of one's inner sensations—is by definition subjective in the sense that it is first-person experience. But that does not mean one cannot try to be as accurate and "objective" as possible regarding one's experience. Nor does it mean that when one perceives objects in the world one is simply addressing one's own subjectivity. One's perceptions are directed toward objects in the world, and this is normally in the service of gaining as accurate an understanding of them as possible. The mistake here is a very fundamental one that really has nothing to do with the psychoanalytic situation per se. One's judgment that there is a rock on the ground in front of one also involves the irreducible subjectivity of personal judgment. Yet the content of the subjective judgment refers to an objective fact about the world—namely, the rock on the ground in front of one—and is either true or false, depending on whether it accurately corresponds to the world.

As Cavell (1998) points out in her response to Renik's "The Analyst's Subjectivity and the Analyst's Objectivity" (1998), "the idea of a perspective on the world that is partial and subjective makes sense only given the idea of a world that is objective, a world that is there,

independently of my seeing it" (p. 1195). Intersubjectivity, interaction, and mutual influence notwithstanding, the patient is part of the "world that is there, independently of my seeing it." His or her mental life is not simply constituted by the analyst's subjectivity, "interpretive constructions," alternative perspectives, or idiosyncratic views.

Renik's philosophical position is not needed in order to recognize or accord due importance to the development of new perspectives in psychoanalysis. Quite often, as we have all observed, adopting a new perspective that makes a difference in one's life follows from discovering a bit of knowledge about oneself hitherto inaccessible and unknown; finding some important truth about oneself almost always shifts one's perspective about oneself, at least to some degree. Rather than there being an opposition between constructing alternative perspectives and trying to discover existing mental contents, it is the discovery of contents that often leads to the deepest and most enduring alterations in perspective.

THE FACTUALITY OF THE MENTAL

One basis for Mitchell's claim (1998) that in understanding the patient one is merely interpretively constructing rather than discovering mental contents is his denial of the factuality of the mental. He does admit that there are "known facts"; for example, he asserts that "generative meaning systems do not work well if they are contradicted by known facts" (p. 10). However, Mitchell limits "known facts" or "factual events" (p. 9) to delineated, readily observable occurrences such as "your mother died when you were five; your father lost his job, became depressed, and was treated with ECT" (p. 9). Inferred psychological events such as "your mother withdrew from you when your younger sister was born; your father gave up hope and became demoralized; or your father tended to act seductively with you" (p. 9) do not qualify as "factual events," but rather are classified by Mitchell as "interpretations of complex interpersonal relationships."

Why does Mitchell count as a "factual event" something like "your mother died when you were five" and *not* as a "factual event" something like "your mother withdrew from you when your sister was born"? Of course, the former is an easily ascertainable historical fact, whereas the latter is complex and certainly far more difficult to ascertain. But that does not make the former a "factual event" and the latter

not. For either the mother withdrew (or withdrew to this or that degree) or she did not. Different aspects of a patient's history may be associated with different methods and ways of knowing. But *when* something happened and *what* someone thought or felt about it are both facts of the world. Neither has an inferior existential status.

Of course, from a psychoanalytic perspective, the critical question is not simply whether or to what degree the mother actually withdrew when the sister was born. One is unlikely to be able to determine whether the mother did in fact withdraw. Nor is one likely to be able to determine whether, at the time the sister was born, the patient *experienced* the mother as withdrawing. All one can reasonably be sure of is that at present, as an adult, the patient remembers and feels that the mother withdrew. But whether the mother withdrew, whether the patient as a small child experienced her as withdrawing, and whether the patient now feels that she withdrew are all matters of fact, some more easily ascertainable and others less so.

That Mitchell denies psychological phenomena factual status is reflected in his statement that "to understand unconscious mental processes in one's mind and that of another is not to expose something that has a tangible existence as one does in lifting a rock and exposing insects beneath" (pp. 17–18). (Ironically, that psychological phenomena such as conscious and unconscious experiences do not have a "tangible existence" was essentially the ground on which behaviorists denied them the status of "factual events" and excluded them from the subject matter of psychology.) What would it mean for any mental content or process, conscious or unconscious, to have a "tangible existence" in the way that insects, tables, overt behaviors, and neurons do? When one sees a red ball or feels tired or has the thought that it is warm today, only one's report of one's experience or mental state (or some other observable behavior, such as yawning or taking off one's sweater) has a "tangible existence" directly observable by others. However, this does not mean that seeing a red ball or feeling tired or having a particular thought is any less real than an ordinary physical event. The absence of a concrete, "tangible" existence in regard to mental events does not make them any less "existent," any less part of the world—something Searle (1998) has repeatedly pointed out with regard to consciousness and conscious experience. It is a legitimate concern that psychoanalytic inferences are often uncertain; however, as Friedman (1998) notes, the issue for many of the new view theorists is not uncertainty but "factuality itself" (p. xvi).

As we have indicated, such a rejection of the factuality of mental content cannot be sustained. As Searle (1998) has repeatedly noted, subjectivity and mental states are as much part of the ontology of the world as tables and chairs. Thus, whereas, say, *being* thirsty is irreducibly subjective, *that* one is thirsty is as much an objective fact of the world as the fact that there are tables and chairs. Of course, the kinds of mental states in which analysts are interested are far more complex than the state of being thirsty, and establishing what the facts are presents far more complex epistemological problems. However, epistemological issues regarding how difficult it is to establish the facts should not be confused with ontological issues concerning whether there are any facts at all. Moreover, that social influences (both developmental and contemporaneous) may shape mental states and that it may be impossible to develop any mental states, as we understand them, without social interaction, does not alter the fact that, once formed, they do exist independently of us and of our "interpretive construction."

UNFORMULATED EXPERIENCE

A further argument that the analyst does not uncover what is in the patient's mind but rather constitutes it through "interpretive construction" is that, even if there is something in the mind, it is extremely vague, inchoate, and ambiguous. Thus, psychoanalytic interpretations shape and give language to hitherto unformulated experiences, and thereby *create* new experience. As Mitchell (1998), puts it, "To understand unconscious processes in one's mind or that of another is to use language in a fashion that actually creates new experience, something that was not there before" (p. 18). This idea is more fully developed by Stern (1999), who observes that certain experiences are unformulated prior to being reflected on and put into words; they are more like "glimmers of meaning" (p. 92), "thoughts not yet thought, connections not yet made, memories that one does not have the resources or the willingness to construct." (p. 12). Stern and Mitchell are arguing, perhaps justifiably, against Freud's assumption that unconscious mental contents are generally clear and distinct representations, fully formed "hidden realities," so to speak, just waiting to be uncovered. A prototype of this view is Freud's idea that the meaning of a dream lies in specific latent thoughts waiting to be uncovered and identified. This way of thinking is also reflected in the idea that once repression is lifted,

distinct unconscious wishes (e.g., oedipal wishes), in no wise different from conscious wishes save that they are unconscious, will enter consciousness.

To recognize that an adequate psychoanalytic theory (or an adequate theory of mind) requires that language and interpretation refer, or attempt to refer, to some kind of existing mental contents (rather than create entirely new experience) does not commit one to the position that those contents are always fully formed "hidden realities" that enter conscious experience unchanged in form and content once repression is lifted. That is, we do not insist that the concept of repression, as traditionally understood, need be the linchpin of a theory that holds onto some idea of reference to preexisting mental contents. We agree with Mitchell and Stern that quite frequently in analytic work, to interpret unconscious contents is to give voice and language to vague, equivocal, and ambiguous "glimmers of meaning." We also acknowledge that quite often language is likely to outrun these vague "glimmers of meaning" and, in that sense, *does* create new experience. But this is true only to a limited degree. For although language and interpretation may articulate an unformulated experience, they do not create its content entirely de novo.

Our claim is that to understand another person one uses language and interpretation to refer, or attempt to refer, to existing mental contents in the other, however vague and unformulated those contents might be in that person's mind. Hence, the question of whether and to what degree language and interpretation "tally with what is real" in the patient remains central. On this view, interpretation entails uncovering and not simply constructing, even if the uncovering does not fit the traditional conception of repression but rather is captured by such locutions as articulating what has remained unarticulated or spelling out what has remained unformulated for defensive reasons (Fingarette 1963, 1969).

It might be the case that a good deal, probably most, of the material interpreted in psychoanalytic treatment consists not of deeply repressed wishes and ideas that emerge in their original form once repression is lifted, but rather of vaguely experienced thoughts, feelings, fantasies, and sensations that have not been spelled out. However, and this is the critical point on which we disagree with Mitchell, language and interpretation spell out *some* existing mental contents, even if those contents are vague and unformulated. After all, when one spells out,

there must be something that is being spelled out. Otherwise, what would it mean to spell something out? Hence, in making interpretations, one both uncovers vaguely felt "glimmers of meaning" and gives voice to, shapes, and elaborates them. Although the uncovering that is involved here may not fit the traditional model of repression, it is nonetheless an uncovering of preexisting mental contents. At the risk of repetition, the central point we want to emphasize is that even when language and interpretation spell out and articulate what is vague, unformulated, and ambiguous, they are "answerable" to existing mental contents in the patient's mind.

Mitchell and Stern are essentially asserting that unconscious contents are best construed as vague and unformulated experiences rather than as distinct wishes, ideas, and fantasies. Given this construal, the appropriate model of defense for them is not banishment from consciousness of clearly delineated mental contents (i.e., repression), but rather the motivated "refusal" to spell out, to process the vaguely felt "glimmers of meaning" any further. In taking this position, Mitchell and Stern are expressing dissatisfaction with traditional conceptions of the unconscious and of repression. Here they follow in the footsteps of others. For example, George Klein (1976) suggested that repression be thought of as the motivated failure to make connections and to understand fully the personal significance of certain experiences.

They follow also in the footsteps of Fingarette (1969), who argued that the essence of much of what is called repression by traditional analysts is best understood as a motivated failure to "spell out" the nature of one's engagements in the world—that is, what one is actually doing, thinking, and feeling. Examples cited by Fingarette include a man's refusal to spell out his recognition that he has been a failure in realizing a certain ambition; Celimene's failure to spell out her jealousy of Arsinoe in Molière's *The Misanthrope*; Hickey's inability to spell out his hatred of his wife in O'Neill's *The Iceman Cometh*; and an example taken from Sartre's discussion of "bad faith" (1956), a woman's reluctance to spell out her engagement in a flirtation. We emphasize that in all of these examples what needs to be spelled out are not inchoate, completely ambiguous experiences but identifiable mental contents: a sense of failure, unacknowledged jealousy, unacknowledged hatred, and unacknowledged flirtation. For defensive reasons, these contents are left vague, unarticulated, and not attended to. But, and this is the crucial point, in spelling them out one does not entirely *create* them.

Rather, one uncovers and articulates them. To put it another way, the notion of spelling out in these examples makes sense only if one holds on to the idea that accurate spelling out makes reference to existing mental contents—that is, tallies with something real in the patient.

As in describing a picture or a cloud, there is a reality, but in putting it into language one has an additional linguistic experience the content of which can correspond only approximately to that of the nonlinguistic experience. However, only when the spelling out corresponds in some degree to the patient's vaguely felt mental content does it elicit a "that's it, that's what I was vaguely feeling" response. Hence, the question to what degree the articulation or spelling out tallies with what is real in the patient remains central, even if what is real exists in the patient in the form of vaguely felt meanings rather than fully formed mental contents.

Consider Green's example of a potential meaning linked to a trauma presumably experienced at a presymbolic stage of development. As Green (1986) states, "although the potential meaning of the trauma may be realizable only in the analytic situation, it is nevertheless the case that "the analytic situation reveals it, it does not create it" (p. 293).

Although one's interpretations may also articulate and give language to representations that have remained unformulated, and that perhaps are not directly and fully recoverable in conscious experience the way wishes and thoughts might be recoverable, the question of whether and to what degree they "tally with something real" in the patient remains central. Let us provide two clinical examples in which although interpretation and language create a new experience by virtue of articulating mental representations never before explicitly formulated, they nevertheless also articulate something that was there all along. The first example is from the treatment of a patient described elsewhere (Eagle 1987) who following the birth of her child suffered a number of panic attacks and became severely agoraphobic. At the time she was living in her parents' apartment, along with her husband and new baby. Following a series of untoward domestic events, she dramatically exclaimed in one session: "Oh, my God! No wonder I had to move back home. This way I can take care of both my mother and Erik [her new baby]." This was a dramatic insight into the way her agoraphobia expressed an "unconscious pathogenic belief" (Weiss and Sampson 1986) to the effect that, "If I leave home and lead a separate and independent life, this will constitute abandoning mother and she will die."

The patient then remembered many incidents and interactions throughout her life in which her mother subtly communicated that message. Although language and interpretation (self-interpretation in this case) partly created a new experience and a new meaning system, they also entailed an uncovering of something actually going on—and that had long been going on—in the patient's mind. That is, although the patient never explicitly articulated the belief that if she left home her mother would die, that unconscious belief had nonetheless long governed her behavior and her affective life.

The second example is that of a twenty-seven-year old man (S.T.) whose presenting symptom was the repeated and distressing occurrence of obsessive thoughts about whether or not he was homosexual. Throughout much of his waking life he would imagine a homosexual scene and then gauge his reaction. If he detected any stirring of interest or excitement in himself, he would become distressed and think, "Oh, my God, I'm homosexual." If he did not detect such stirrings, he felt relieved and reassured, but only until the next test. His obsessive symptom first developed when his girlfriend pressed him to agree to a formal engagement as a step toward marriage. It should be noted that S.T. was brought up in a fundamentalist Christian home (when he began treatment he still lived with his parents) and was himself quite religious. He felt that homosexuality was a grievous sin against God and proclaimed in one session that if a tidal wave were to wipe out San Francisco, it would be fitting punishment for that hotbed of homosexuality.

In spelling out the functions served by S.T.'s homosexual preoccupations, and in articulating and giving language to the patient's vaguely felt sense that his symptom was in some way linked to his relationship with his girlfriend, a new experience was generated that was not there before. Something similar occurs with any insight or spelling out. The therapist was giving voice to something—to the specific link between the patient's homosexual preoccupation and the dangers of heterosexual intimacy—that was *not* there before, whether as implicit unconscious content or procedural knowledge.

To sum up, even vaguely felt meanings have some content and "aspectual shape" (Searle 1998) that will be captured more or less accurately by some linguistic descriptions and not by others. In reacting against Freud's assumptions that psychic reality "exists in a form which is neither ambiguous nor equivocal, but clear and distinct" (Carlo Bonomi, personal communication), the new view theorists seem

to take the position that unformulated experiences are so amorphous and indeterminate that they simply await language ("interpretive construction") to be given any shape at all—that is, to be created, by oneself and particularly by the other. But this is a description of unformulated experiences and "felt meanings" as sheer putty, as something with no content or shape at all, simply waiting to be given *any* shape or content by language and "interpretive constructions." But "felt meanings," though they may be vague, are of one sort and not another and are not totally amorphous and indistinguishable from one another. Hence, it follows that only certain attempted articulations and interpretations will capture them—that is, will be more accurate than others. This would not be the case were language and interpretation entirely (or even primarily) to create experience rather than to articulate, however successfully, something already "there."

IS MIND PREORGANIZED?

An additional basis for Mitchell's position that the analyst interpretively constructs rather than attempts to discover the patient's mental contents is his claim that even if there are some preexisting mental contents, the psychoanalytic process creates their organization. Specifically, Mitchell (1998) rejects "traditional claims . . . that the central dynamics relevant to the analytic process are preorganized *in the patient's mind* and that the analyst is in a privileged position to gain access to them" (p. 18). Mitchell's position here has led Meissner (1998) to comment that "It seems odd . . . that one would think of the patient, as he enters the consulting room for the first time, as without a history entirely of his own, without developmental background, without a psychology and personality that he has acquired and developed in the course of a lifetime, all accomplished before he had any contact with the analyst" (p. 422). Why would Mitchell take such an odd position? He appears to do so because he wants to defend the idea that the organization of the patient's mind is constructed through interaction with the analyst and thus counter to what he sees as the traditional view that there is an organization of mind that would unfold in the same way in all psychoanalytic situations.

In a recent reply to Silverman's critique (2000) of the same 1998 paper we are discussing, Mitchell (2000) attempts to clarify "misreadings" of his position. (Because of the extreme nature of some of

his statements, it is at times difficult to distinguish misreadings from plausible interpretations of Mitchell's 1998 paper; one's initial reaction is to say to oneself, "He couldn't really mean that.") In his reply, Mitchell denies he ever claimed that the mind has no preexisting properties prior to analysis: "There is no place in any of my writings in which I argue against the idea that the patient has a mind with preexisting properties before ever encountering the analyst or that there are no continuities among the versions of ourselves that emerge with different people. This would, of course, be preposterous" (p. 155). However, he continues to claim that the mind is not preorganized: "But I think a problem with preconstructive thinking is the assumption that there is a static organization to mind that manifests itself whole cloth across experiences. A very good description of the way I think about mind as *preexisting but not preorganized* is to be found in Ogden (1997)" (p. 155).[2]

How does one understand the claim that mind is "preexisting but not preorganized"? Presumably, the preexisting mind exists in some organized form. But Mitchell wants to reject the idea of a "static organization" of mind and, as his reference to Ogden suggests, wants to emphasize the mind's susceptibility to being organized in different ways as a function of the particular "intersubjective relationship" in which the person is engaged. Implicit throughout Mitchell's 1998 paper and certainly suggested by the "clarifying" idea of "preexisting but not preorganized" is a "relational" conception of mind in which it has no inherent character of its own, in which it is indefinitely fluid and malleable, waiting to be shaped and organized by—to quote from the passage by Ogden that Mitchell says captures his thinking—"each new . . . intersubjective relationship."

But susceptibility to being influenced by one's interaction with another does not mean that one's "preexisting" mind has no preorganized stable structure prior to that interaction. Even if this view of mind as lacking a stable organization is accurate for the young infant—and it is far from clear that it is—it is not true of an adult who has formed relatively stable and organized structure in the course of his or her development.

[2] The passage cited from Ogden (1997) states that "the internal object relationship . . . is not a fixed entity; it is a fluid set of thoughts, feelings, and sensations that is continually in movement and is always susceptible to being shaped and restructured as it is *newly* experienced in the context of each new unconscious intersubjective relationship . . ." (quoted in Mitchell 2000, p. 155).

People who come to treatment (and, to a certain extent, people in general) indeed show repetitive and "static" patterns of behavior, underlying mental contents (e.g., unconscious wishes and fantasies), and representations (e.g., internal working models and interactional structures) across a range of situations. The suggestion that psychic organization is easily and "always susceptible to being shaped and restructured . . . in the context of each new unconscious intersubjective relationship" (Ogden 1997, p. 190) places all the emphasis on what Piaget (1954) called accommodation and very little on our ubiquitous and powerful tendency to assimilate ongoing experience, including novel experience, to *preexisting and preorganized* schemas and representations. Were people as readily susceptible to being shaped and restructured by each new intersubjective relationship as Mitchell and Ogden suggest, therapeutic change would be much easier than it is. People are, of course, capable of change, but it is made especially difficult by our very strong and, in many respects adaptive tendency to operate on the basis of relatively stable structures.

Mitchell's puzzling distinction (2000) between preexisting and preorganized mental processes does little to make his conception of mind more tenable. It lands one in the difficult position of having to argue that although "the patient has a mind with preexisting properties before ever encountering the analyst"—to deny that, Mitchell tells us, would "be preposterous"—the patient's mind is not "preorganized," a claim that is no less preposterous. Mitchell's acknowledgment that the mind is preexisting, coupled with his denial that it is preorganized, grants to the mind no more reality than the Cheshire cat's smile. Thus, in the end what Mitchell labels a misreading of his position appears to be but a spelling out of its implications—even if he is reluctant to directly endorse them.

Mitchell might be construed as simply making the modest point, underemphasized in traditional theory, that the interaction between patient and analyst exerts some influence on the organization of the patient's mind and on the particular dynamics that are most readily elicited. For example, in his 2000 paper Mitchell writes, "the only way the analyst can know anything about the mind of the patient is in interaction with his or her own mind. Therefore, to some very important extent, the versions of the patient that emerge in the analytic process are unique to this particular analytic relationship and cogenerated by the analyst's own witting and unwitting participation" (p. 157).

To make the point, however, that there is an interaction between the patient's dynamics and the personality and behavior of the analyst hardly requires the radical conception of mind that Mitchell presents. Moreover, although some aspects of the patient that emerge in the analytic process may be unique to a particular analytic relationship, other aspects are likely to be stable across the patient's other relationships. Mitchell's situational bias leads him to underemphasize the fact that some internal predispositions are so intense and have such a low threshold for activation that they are readily elicited by a wide range of situations.

Mitchell's position regarding preorganized dynamics brings to mind an early debate in personality theory between trait theorists (who argued that individual differences in behavior are determined primarily by internal stable traits) and situationists (who argued for their determination primarily by situational variables). The obvious resolution to this somewhat unnecessary debate lay in the recognition that behavior is the product of an *interaction* between internal predispositions (including preorganized central dynamics) and situational cues and demands. For example, a piece of glass can break in many different ways, depending on the nature and force of the impact on it. This, however, does not mean that the glass does not have preorganized structural properties. How it breaks will be a function of the interaction between those properties and the forces that act on it. One does not say that the glass has preexisting but not preorganized properties.In the psychoanalytic context, consider as an example a male patient who has intense competitive strivings and little conflict about expressing them. This aspect of his personality can be expected to emerge more readily (in one form or another) with an analyst who behaves in an authoritarian or competitive manner and less readily with a more "maternal" analyst who does not "pull" for such themes. Thus, some transference-countertransference configurations will be unique to a given dyad, and some stable aspects of the patient's personality will emerge to some degree in most analytic relationships. One does not need a new theory of mind to account for these simple observations.

Traditional psychoanalysis, object relations theory, and self psychology have heavily emphasized strong internal predispositions (e.g., wishes, fantasies, defenses, internalized object relations, long-standing inner conflicts, self defects), perhaps at the expense of recognizing the importance of interactional factors. Mitchell appears to

be reacting against this tendency. Thus, traditional psychoanalysis can be read as maintaining that for each patient there is a static, fixed set of unconscious wishes, conflicts, fantasies, and defenses that will inevitably emerge with any analyst. This position may lead the analyst not only to be certain that he or she knows what is in the patient's mind, but also to overlook his or her influence in eliciting it. Thus, the idea that there is something preorganized in the patient's mind to be uncovered is objectionable to Mitchell because he sees it as according insufficient influence to the analytic interaction. If Mitchell's position is understood as a corrective to this relative neglect of interactional factors, it is welcome. Unfortunately, however, Mitchell anchors his view in untenable theories of mind that provide no adequate basis for psychoanalytic theory or practice.

A DISJUNCTION BETWEEN CONCEPTUAL STANCE AND CLINICAL MATERIAL

Friedman (1998) observes that it is "hard to imagine how an analyst would work who no longer believes in hunting for something that is already there to be discovered" (p. 261). That it is hard for Mitchell and Renik to imagine this is suggested by two pieces of evidence. One is the disjunction between the conceptual stance they take and the clinical material they present. The other piece of evidence is the need to preserve the idea that, after all, psychoanalysis does deal in the currency of truth and objectivity, even if that requires some rather odd redefintions of these concepts. We will discuss each of these issues in turn.

Although maintaining that there are no mental processes corresponding to the phrase "in the patient's mind" about which one can be right or wrong, and after arguing that there are no "preorganized" central dynamics in the patient's mind, Mitchell nevertheless proceeds to interpret his patient Robert's dream in terms of "his struggles with his son [that] were in some measure reflective of struggles with a part of himself that had been buried" (p. 23). He notes that the patient's father "was internalized by him in a complex fashion" (p. 23) and notes also the patient's struggle "with the sense that he has tragically mutilated his own inner resources and potentiality" (p. 24). Here Mitchell certainly writes as if these struggles and internalizations qualify as preorganized central dynamics "in the patient's mind" about which one could be right or wrong.

Despite his preference for the new view over the older idea of uncovering, Renik's interpretation (1996) that his patient's hostility and guilt toward her sister served as a defense against being critical of her parents speaks to an uncovering of the patient's hitherto inaccessible feelings toward her parents. As Smith (1999, p. 468, n. 1) has noted, the specific clinical formulations and interventions described by Renik, rhetoric notwithstanding, are not appreciably different from those any analyst would be likely to make. Thus, the interpretation is not simply "Why don't you take this perspective toward your anger at your sister?" but also "There is more to your anger and guilt toward your sister than meets the eye"—more to be uncovered. Without the assumption that the patient unconsciously harbors critical feelings toward her parents—that is, without the assumption that such feelings are "in the patient's mind"—Renik's interpretation becomes, in essence, nothing more than "Look at your hostility and guilt toward your sister this new way—it will help you feel better." Without any concern that one's interpretation correspond in some way to what is "there" in the patient's mind, a whole range of interpretations or perspectives could conceivably help the patient feel better. How, then, would this view differ from suggesting, say, becoming a born-again Christian or an orthodox Jew in order to feel better?

REDEFINING TRUTH AND OBJECTIVITY

The other way that new view theorists exhibit their discomfort with a complete dismissal of the question of whether analytic interpretations tally with something real in the patient—that is, possess truth and objectivity—is to redefine these concepts and thus preserve the language of uncovering while rejecting its substance. Renik's solution to the uncomfortable possibility that new perspectives that (purportedly) are effective in analysis may have little to do with the truth is simply to redefine truth so that "what is true *is* what works"(1998a, p. 492)—when it is clear that what he means by "what works" is whatever increases the patient's happiness.

In an apparent recognition that there might be difficulties with his equation of what works with what is true and objective, Renik raises the question of whether he would regard as objective a patient whose grandiose delusion brings happiness. His answer is that in his experience "delusional grandiosity does not, in the long run,

make people happy. . . . If the patient's happy self-satisfaction did, in fact, seem to last, however, I would feel obliged to review my perception of the patient as delusionally grandiose" (pp. 494–495). So intent is Renik on clinging to his idiosyncratic conception of objectivity that if the delusion (now only apparent) has made the patient happy for a sustained period (how long he doesn't say), he would feel obliged to believe that the patient has been objective rather than delusional. What if someone has a blatant delusion, say, that he is the King of England, and what if this delusion makes him happy over a long period? Would Renik feel obliged to review his perception of the person as delusional? Would he not want, instead, to review his assumption that delusional grandiosity cannot ever, in the long run, make anyone happy? Otherwise, he is forced to say that what appeared to be delusional is not after all, really so. Would he then conclude that the patient is indeed the King of England?

As for the issue of objectivity, Renik's answer to the question "how can an analyst be objective if an analyst is irreducibly subjective?" (p. 491) is simply "that in analysis, as everywhere in life, observations of reality are constructs, formed in relation to specific subjective interests" (p. 491). To illustrate the determination of observations by subjective interests, he contrasts a hiker's observations of the sun rising in the east and setting in the west with an astronomer's observations, which "show that the sun does not move through the sky at all" (p. 492). Renik's conclusion is that "though it could be argued that the hiker's and the astronomer's observations are in contradiction, we can also say that they are both *objective,* each in relation to a different *subjective* interest" (p. 492).

Apply Renik's reasoning to a hiker who experiences the earth as flat—which, of course, is the way we all do experience the earth in our daily interactions with the world. According to Renik's logic, the hiker (or anyone else who experiences the world as flat) and the astronomer, whose observations reveal it as round, "are both *objective,* each in relation to a different *subjective* interest." But this conclusion is, of course, mistaken; the earth is round, and hikers walking on flat paths know that as well as the astronomer, despite their highly adaptive subjective experience of the earth as flat.

Perhaps what Renik wants to say is that for the "subjective interest" of negotiating our everyday activities, the experience of the earth as flat, or even the belief that it is, is perfectly adequate. However,

it turns out that our subjective experience of the earth as flat is not an adequate basis for determining the objective nature of the shape of the earth as a whole. One cannot, then, legitimately say that the statements that (1) the earth is flat, and (2) the earth is round are equally objective, but each in relation to a different subjective interest. The first proposition is false. These examples show the difference between a heuristic that "works" and a proposition that is true. Thus, although the heuristic that the earth can be considered flat works for many purposes, it is literally false.

As Cavell (1998) cogently notes in her response to Renik's article, the fact that one's perception and observations may reflect one's "subjective interests" and are idiosyncratic and personal in no way precludes the idea of an objective world independent of our perceptions. Indeed, she says, "The idea of a perspective on the world that is partial and subjective makes sense only given the idea of a world that is objective, a world that is there, independently of my seeing, that can be seen from different points of view while remaining the same world" (p. 115).

Cavell's position here is virtually identical to that of Searle (1998) in his comments on "perspectivism." His characterization of perspectivism could well serve as a description of Renik's views. It is "the idea that our knowledge of reality is never immediate, that it is always mediated by a point of view, by a particular set of predilections . . . " (p. 18). However, as Searle notes, the idea that in order to know reality one must know it from a point of view in no way precludes the possibility of knowing reality objectively. To assume that it does entails the remarkably simple but erroneous assumption that in order to know reality one must approach it from *no* point of view. "I directly see the chair in front of me," writes Searle, "but of course I see it from a point of view. I know it directly from a perspective" (p. 21). But it would make no sense to talk about different points of view or perspectives regarding the chair unless there were a real chair existing independently of our observations.

Similarly, it makes little sense to talk about different perspectives on a patient's mind unless one assumes that there exist relatively stable mental states, dynamics, defenses, wishes, needs, desires, schemas, and so forth on which the analyst takes a perspective. Of course, unlike perceiving the chair, it may be difficult, sometimes impossible, to ascertain a patient's mental states. It is also the case that unlike

perceiving an inanimate object like a chair, in the analytic situation (as in other interpersonal situations) the parties interact and mutually influence each other's mental states. However, there is a difference between, on the one hand, recognizing that one influences and has a certain perspective on another's mental states, and, on the other, denying their independent existence.

Mitchell and Renik share in common the view that psychoanalysis is in the business of generating meaning systems, perspectives, interpretations, constructions, narratives—whichever term one prefers—that purportedly will lead to a richer and less self-sabotaging existence. All the other talk, including labored definitions or redefinitions, whether of the mind, truth, insight, or objectivity, are beside the point. Although the logic of their position suggests that the truth of a narrative—that is, whether it corresponds to something real in the patient—is largely irrelevant, and although they come close to saying just that, they disguise their plunge into postmodernism by engaging in semantic gymnastics.

We suggest that in addition to not wanting to appear "irresponsible relativists," another reason that new view theorists cling to the idea that they are concerned with truth, objectivity, and so on, is that virtually all patients assume, when they enter treatment, that they will gain self-knowledge and learn more of the truth about themselves. If this assumption is simply an illusion, why are patients not disabused of this notion? As Sass (1992) asks, is the presumed impossibility of determining the veridicality of interpretations a secret being kept from patients? Do patients really believe there is nothing corresponding to the phrase "in the mind" about which they or their analysts can be right or wrong? Do patients accept the goal of becoming simply "relative historians" of their lives (Schafer 1992)? When Renik makes the interpretation to his patient that her anger at her sister is partly a defense against feeling critical and angry toward her parents, does she interpret this intervention as merely a "new perspective" that might "work" for her, or does she understand Renik to be saying that she actually and in fact harbors such feelings toward her parents? One wonders how long patients would remain in treatment were they told the analyst is interested not in uncovering truths, but rather in offering "aesthetic fictions" (Geha 1984), coherent narratives, or the like. One wonders also how well analysts could conduct treatments if their general philosophical ideas, as presented in journal articles and books, fully infiltrated their day-to-day clinical work.

The reluctance of new view theorists to relinquish the appearance of a concern with truth may be based on their intuition that it is difficult to understand how the psychoanalytic project can survive when the "interpretive constructions," meaning systems, narratives, perspectives, and so on, that are formulated in psychoanalysis are freed from any link to something real in the patient. It seems to us that the tortured redefinitions of truth and objectivity offered by these theorists are an attempt to preserve the psychoanalytic project while undermining its basic assumptions.

In summary, when they talk about clinical material, they implicitly hold on to traditional ideas of preexisting mental contents despite their explicit embrace of a conceptual stance that contradicts those ideas. They attempt to evade the implications of their conceptual stance by convincing themselves and others that they continue to believe that truth and objectivity are essential concerns in psychoanalysis, even while they redefine these concepts in ways bearing little relation to how these terms are ordinarily understood.

THE NATURE AND GOALS OF PSYCHOANALYTIC TREATMENT

It seems to us that, at rock bottom, Mitchell, Renik, and many other contemporary psychoanalytic writers are arguing, against the traditional view that insight and learning the truth about oneself are crucial to therapeutic change, that new meaning systems, alternative perspectives, and more coherent narratives are the real mutative agents. Hence, according to them, a central project of psychoanalysis is not uncovering truths about the patient's mind but developing or constructing new meaning systems, perspectives, and narratives that presumably make for a better life. This is a relatively simple idea that does not require philosophical discourses on the nature of mind or on the possibility of discovering truths about the mind.

If the name of the game, so to speak, is the provision of meaning systems or alternative perspectives that make for a better life, then the central operative questions are (1) whether patients do, in fact, adopt new meaning systems and new perspectives; (2) whether this or that meaning system or alternative perspective indeed makes for a better life; (3) what one means by a better life; and (4) how one goes about determining or "measuring" the degree to which such an outcome has or has not occurred.

At the heart of Mitchell's position, and that of much contemporary analytic writing, is a disillusionment with the core traditional idea, linked to the "Enlightenment vision," that insight, awareness, and self-knowledge—that is, gaining access to one's unconscious mental contents and modes of defense—is an important route to liberation and therapeutic change. Disillusionment with the role of insight has, we believe, at least two sources. One is the familiar clinical experience that insight and awareness do not *necessarily* lead to significant therapeutic change. The other source is the more epistemological problem of suggestion, namely, the question of whether interpretations that appear to generate insight really correspond to what is going on in the patient's mind. By adopting the framework offered by Mitchell and Renik, the analyst is freed of the burden that accompanies the claim that interpretations tally with something real in the patient—that is, that the analyst uncovers or discovers anything.

Thus, in one conceptual fell swoop, analysts can unburden themselves of a dogged epistemological problem. By relinquishing the idea that analysts uncover anything in the patient's mind and adopting a thoroughly constructivist position, analysts can avoid the discomfort of what Mitchell (1998) calls the "Grünbaum syndrome" and can assure themselves of the "almost total irrelevance to contemporary clinicians" (p. 5) of Grünbaum's well-known critique. The problem is that however inconvenient the role of insight in therapeutic change, it is not a conceptual or philosophical issue but an empirical-clinical one.

It should be noted that we are arguing neither that insight, as traditionally defined, is more therapeutically effective than coherent narratives or new meaning systems, nor whether disillusionment with the traditional goals of insight is justified. These are empirical issues. We are arguing against the position that because there is nothing corresponding to the phrase "in the patient's mind" about which one can be right or wrong, or because of the presumed impossibility of knowing the patient's mind, the only option available for analysts is the provision of alternative perspectives, coherent narratives, and new meaning systems.

CONCLUDING REMARKS

As we noted at the beginning, the writings of new view theorists have served a useful purpose. They have helped dismantle the myth that the analyst is a purely objective observer; made us more aware of the subtle

and complex interactions between patient and analyst; highlighted the role of the analyst's idiosyncratic style, history, and biases in his or her understanding of the patient; and helped dispel what Stone (1981) referred to as the "robot-like anonymity of our neoclassical period" (p. 106). However, in the course of offering useful critiques, they have taken positions that are themselves untenable and provide no fruitful basis for the growth and development of psychoanalysis. Thus, in the course of arguing against the straw man of "pure objectivity" (Smith 1999, p. 468), they have adopted an extreme subjectivist position that, as Cavell (1998) notes, leads to "frank skepticism about the very existence of the external world and other minds" (p. 453). It is one thing to acknowledge the role of the analyst's idiosyncratic history, views, and biases. It is quite another to argue against the claim that the analyst tries to address the patient's psychic reality and to find the patient's views. However imperfect and incomplete the effort may be, one can try to take account of one's biases and attempt to understand the patient as accurately as possible. The alternative view, that in understanding the patient the analyst is in fact addressing his or her own psychic reality, locks one into a solipsistic position that in effect eliminates the independent existence of the other.

One major impetus for the writings of the new view theorists was their objection to the purported classical position that the analyst, as a purely objective observer, has virtually direct access to a singular canonical Truth—a sort of God's-eye perspective—about the patient's mind. This stance, it was held, too easily lent itself to imposing the analyst's theoretical views on the patient and therefore ran the high risk of violating the patient's integrity. There is a great irony in the observation that in reacting against traditional views—that is, in disputing the ideas that we *are* trying to find the patient's view, that the patient comes to treatment with preorganized central dynamics, that there is something in the patient's mind about which we can be right or wrong—and in effect maintaining that the patient's mind is constituted by the analyst's "interpretive constructions," one violates the independence and integrity of the patient far more profoundly than the traditional view purportedly does. For, as long as one holds as an ideal that one's interpretations are to be constrained and evaluated according to the degree to which they "tally with something real" in the patient, they are answerable, at least in principle, to the reality of the other's independently existing mind. Once one relinquishes that ideal and takes

the position that one constitutes the other's mind through "interpretive construction" and interaction, or that in trying to understand another's psychic reality one is in fact addressing only one's own, the very existence of other minds, structured independently of the analyst, is called into question, and one is in the business of creating, not understanding, the patient.

Upholding the ideal that one is trying to understand the patient's independently existing psychic reality leaves room in principle for the correction of arrogant and overly certain views. The independent reality of the other and the ideal of trying to find the other's views are always there as constraints on constructions and as "limits to the extent of interpretive latitude" (Kirshner 1999, p. 449). There are no comparable constraints and limits so long as one maintains that one is addressing only one's own psychic reality, that "there is nothing corresponding to the phrase "in the patient's mind" that patient or analyst can be right or wrong about.

In our view, the most constructive and fruitful philosophical position for psychoanalysis is a "humble realism." That position holds that a central task for psychoanalysis is the attempt to understand, as deeply and as accurately as possible, the patient's psychic reality and to find his or her views. This position allow us to recognize the analyst's idiosyncratic biases, history, and eliciting cues, as well as the uncertainty and limits of our understanding. Instead of proclaiming at every turn the analyst's "irreducible subjectivity" and the supposed impossibility of any objective view, one simply does the best one can in trying to understand the psychic reality of the patient as accurately as possible.

Adopting a position of humble realism obviates the temptation to dichotomize between the therapeutic process goals of uncovering and discovering, on the one hand, and of developing new meaning systems and alternative perspectives on the other. One recognizes that the two go hand in hand. If we are not concerned with whether our meaning systems, perspectives, interpretations, and narratives correspond in some way to what is going on in the patient's mind, we are left with an endeavor not essentially different from any form of suggestion, persuasion, or conversion. As Kirshner (1999) puts it, "if we forget about what is really out there . . . , we are left with a socially constructed theory that can be viewed pragmatically, as useful to peers and patients who agree to employ it" (p. 450). We would certainly have to give up any pretensions that psychoanalysis has much

to do with such things as how the mind functions and how personality develops.

A position of humble realism as a philosophical underpinning for psychoanalysis enables us to recognize the uncertainty of our knowledge of the other (and of ourselves), the role of the analyst's idiosyncratic history and biases in understanding the other, the mutual influence between patient and analyst, and the indirect and inferential nature of our knowledge of another's mind, but to recognize also the independent existence of the patient's psychic reality and the need to understand that reality as fully and as accurately as possible.

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