Int J Psychoanal (2009) **90**:231–248 doi: 10.1111/j.1745-8315.2009.00132.x

Grasping psychoanalysts' practice in its own merits[1]

Juan Pablo Jiménez

Departamento de Psiquiatría y Salud Mental Oriente, Universidad de Chile, Av. Salvador 486, Santiago, Chile – jjimenez@med.uchile.cl

The central objective of this presentation is to reflect on the obstacles involved in the task proposed by the Chicago Congress, which is to explore convergences and divergences in psychoanalytic practice. The author discusses two major obstacles. First, the epistemological and methodological problems in relation to the construction of theory in psychoanalysis and especially the inaccessibility, in any reliable way, of what psychoanalysts really do in the intimacy of their practice. He proposes to separate, at least in part, theory from practice in psychoanalysis, in an attempt to grasp psychoanalysts' practice in its own merits. He then outlines a phenomenology of the practice of psychoanalysis, which reveals that, in their work with patients, analysts are guided more by practical reasons than theoretical reasons; that is, their interventions are predictions rather than explanations. Since these practical reasons need to be validated constantly in the analytic relationship based on their effects, he discusses the subject of validation in the clinical context of the core theory of therapeutic change in psychoanalysis, that is, the conditions required for clinical practice to satisfy the thesis of an inseparable union between gaining knowledge and cure. He ends by challenging the core of the psychoanalytic theory of change, arguing that it neither does justice to the practice of psychoanalysts nor to contemporary knowledge of processes and mechanisms of therapeutic change. Finally, he proposes that we detach practice from theory, in order to study the former in its own merits, utilising a plurality of methods ranging from systematic investigation to the recent methodology of the Working Party.

Keywords: clinical validation, pluralism, practical reasons, psychoanalysis and truth, psychoanalyst's mind, psychoanalytic phenomenology, psychoanalytic practice, psychoanalytic theory, psychoanalytic theory of change, theoretical reasons, working party

La théorie c'est bon, mais ça n'empêche pas d'exister.
(Charcot)

Psychoanalysis is what is practiced by psychoanalysts.
(Sandler)

Introduction

The panorama of contemporary psychoanalysis is complex. As never before, the controversy surrounding its epistemological status has entered even the psychoanalytic movement. The subject of this Congress speaks for itself. Now, it is not only the theoretical unity of psychoanalysis that is being questioned, but also the unity of its practice. We are therefore convoked to

[1]This paper will be presented as a keynote lecture at the 46th Congress of the International Psychoanalytical Association, Chicago, 29 July – 1 August 2009, under the title 'Psychoanalytic Practice: Convergences and Divergences'. Registration is available from the IPA's website at: http://www.ipa.org.uk

Published by Blackwell Publishing, 9600 Garsington Road, Oxford, OX4 2DQ, UK and 350 Main Street, Malden, MA 02148, USA on behalf of the Institute of Psychoanalysis

reflect on what unites us and what separates us. In this presentation I hope to show that the task we face is plagued with obstacles difficult to overcome, first, because of the conditions in which theory in psychoanalysis is constructed and, second, because of difficulties for reliably accessing psychoanalysts' practice: what psychoanalysts *really do* in the intimacy of the therapeutic relationship.

It is true that this issue goes beyond psychoanalysis, encompassing clinical practice in Mental Health. When I was a young psychiatrist dreaming of becoming a psychoanalyst, I felt uncomfortable about the ease with which my colleagues generalized the knowledge they acquired from studying individual patients. However, something else alarmed me even more: the suspicion that, when clinical practitioners give an account of their experience with patients, they tend to bias clinical reality until it fits into established categories, favourite theories or the thinking of the author in fashion at the time. Hence, they speak, not about what they actually do (or say) in their consulting room, but about what they would like to have done (or said), presenting idealized clinical work – which makes exchange among colleagues tremendously difficult (Jiménez, 2005, p. 608). Of course, I am aware in the first place that this is not simply a question of a more or less intentional cover-up by the person presenting clinical material, a product of adhesion to psychoanalytic schools and ideologies, or of submission to the 'technical superego' regulating 'politically correct' public exchange (Figuera, 1994) among psychoanalysts, but also of the impact of implicit theories (Canestri *et al.*, 2006), which is to say the effect of unconscious reasons guiding our practical action with our patients. With this I wish to emphasize how difficult it seems to be in psychoanalytic discussions to stay in contact with the patient without rapidly diverting the discussion to various levels of theories *regarding* practice or even to ideas of psychoanalytic authors who in turn construct theories about practice. This could have something to do with the dominant trend in all psychoanalytic cultures to place too much trust in theoretical definitions that leave a great deal of latitude and an under-reliance on grounded empirical study (Tuckett, 2006). This becomes a problem if we wish to remain loyal to Freud's assertion that, no matter how far it may have come, psychoanalysis ''has not abandoned its home-ground and it is still linked to its contact with patients for increasing its depth and for its further development'' (Freud, 1933a, p. 151).

You may have noticed that I am assuming that it is possible to separate, at least in part, theory from practice in psychoanalysis and that it is even worth trying to grasp psychoanalysts' practice in its own merits. I know that many will question this assumption. My response is pragmatic: before you reject it for 'theoretical' reasons, I invite you to examine the heuristic value of this separation.

Very early in my professional career, I was interested in clinical epistemology (Jiménez, 2005) and especially in methodology, considered to be the study of the rules and paths leading to 'good' inferences and from there to the enrichment of valid clinical knowledge able to produce a consensus, to be communicable and, above all, refutable, at least, through collective discussion and rational argument. Even further, epistemological reflection

grounded in my previous studies of philosophy cultivated my growing dissatisfaction with the clinical method as the only source of acquisition of knowledge in psychoanalysis and led me to become interested in different aspects of systematic investigation in psychoanalysis: empirical investigation in process and results, investigation into the early mother–infant relationship and conceptual investigation. In recent years, moved in part by a need for academic exchange with my psychiatric colleagues, I have been amazed at the developments of the new biology of the mind (Jiménez, 2006) which enable us to return to the path of 'neuro-psychoanalytic' integration abandoned by Freud in 1895. In these 25 years, I have been looking for ways to articulate psychoanalytic knowledge with allied disciplines and have learned methods with varying degrees of sophistication which may be applied to 'traces' or registers of psychoanalytic processes. Lately, I studied the fascinating combinations between registers of processal subjective variables and dynamic images of brain functioning.

Theoretical and practical diversity in psychoanalysis is a fact that few would argue today. As long ago as 1966, Philip Seitz (1966) demonstrated that expert psychoanalysts cannot reach any reliable agreement on interpretations based on inferences regarding complex internal states. Later, Pulver (1987a, 1987b) and Bernardi (1989) drew similar conclusions. Even so, it is questionable to describe this situation in terms of pluralism, since what seems to exist is mere plurality or worse yet, theoretical and practical fragmentation, since at this time we have no methodology for a systematic comparison of diverse theories and technical approaches. Ricardo Bernardi (2005) wonders what will happen after this pluralism if the necessary conditions are not created for the diversity we observe to become a factor of progress rather than destruction for psychoanalysis. His investigations (Bernardi, 2002, 2003) on the way psychoanalysts argue in controversies leave us with a feeling of pessimism about our ability to find a common ground. On the other hand, Tuckett considers this situation an opportunity for change:

> It is time not only to review our methodology for assessing our truths, but also to develop approaches that will make it possible to be open to new ideas while also being able to evaluate their usefulness by reasoned argument. The alternative is the Tower of Babel.
>
> (Tuckett, 1994a, p. 865)

Of course, this exuberant diversity of theories is an inevitable product of clinical practice. In their eagerness to preserve the vitality of the analytic situation, analysts necessarily modify their technique in a more or less idiosyncratic way, sometimes departing quite a bit from 'standard' technique, which is the one they internalized as 'proper analysis'. These technical modifications are related more to an ''intrinsic private preconscious theory about the patient's material than [to] official public theories to which the analyst may consciously subscribe'' (Sandler, 1983, p. 38). We psychoanalysts are experts in constructing narratives whose details aim to grasp the singularity of their patients' subjectivity. It is highly probable that developments of psychoanalytic theory in the course of

history stem precisely from the fact that some of these private theories were 'made official'. The problem is not here but in the unnoticed passage and in a confusion of levels of abstraction. These theoretical fragments, products of inductive inferences that apply quite well to a particular patient, are assigned a universal value that they do not have, which engenders an official 'over-specified' theory (Fonagy, 2006). Ultimately, this spurious generalization is the reason for the 'confusion of tongues' in constructing theory in psychoanalysis.

Toward a phenomenology of practice in psychoanalysis

The question I ask in relation to psychoanalytic practice can be put this way: *How can we be sure that we see clinical practice exactly as it is, that we know it in its own reality and are not simply projecting our own theories onto it?* It is obvious that conceptual systems are absolutely necessary for everyone who aims to observe a reality and communicate what they have seen in a valid way; however, when we are dealing with intersubjective processes, the need for validity is as necessary as it is difficult, and the risk of apriorism in the schemata becomes a problem. We have for too long underestimated the complexity of the clinical situation and have assumed a simple and direct relation between theory and practice in psychoanalysis.[2] The undeniable existence of different practices requires us to develop a method for describing these differences in a reliable manner.

In his study of debates during the 1970s in Buenos Aires and Montevideo, when Kleinian ideas came into contact with Lacanian thinking, Bernardi (2003) showed that difficulty in establishing genuine controversies which would serve the development of our discipline does not depend so much on the characteristics inherent to theories (as, for instance, their incommensurability), as on defensive strategies aimed at protecting the premises of each theory from the opponent's arguments. Therefore, difficulties in dialogue should not to be attributed to theoretical reasons as much as to practical reasons. Of course, this situation, with an absence of real confrontation between different viewpoints, has blocked the formation of a coherent theoretical–practical corpus in psychoanalysis. Even further, difficulties multiply when we try to share clinical practice itself.

The first obstacle is precisely that we assign no status of its own to practice independent of theory. Instead of a debate based on arguments and clinical examples, what we tend to observe is a purely 'theoretical' debate which omits the peculiarities of practice. The second obstacle is even thornier. His study of the series, *The Analyst at Work*, published in the *International Journal of Psychoanalysis*, leads Tuckett to assert that ''the tradition of psychoanalytic discussion of a colleague's clinical material is, so to speak, to supervise it'' (Tuckett, 2007, p. 1047). Supervision

[2]For example, Etchegoyen establishes a bi-univocal relation between theory and practice when he states: ''Just as there is a *strict correlation* between psychoanalytic theory and technique and research, psychoanalysis also relates, and singularly so, technique with ethics'' (Etchegoyen, 1986, p. 27, my italics).

of the material presented seems to be the habitual pattern of discussion in psychoanalytic societies and international congresses. Personally, I was in charge of the final report of the different panels which discussed clinical material presented by Helmut Thomä at the psychoanalytic congress in New Orleans. Beforehand, Thomä had expressed his fear of not being understood and not being discussed on his own terms, being instead 'supervised' on the basis of panellists' favourite theories (Thomä, Jiménez and Kächele, 2006, p. 193f).[3] In a recent paper, Thomä and Kächele (2007) assert that if ''comparative psychoanalysis [is to be] a fruitful enterprise, it is essential to evaluate how the treating analyst applies his professional knowledge in specific interactions'' (p. 651). Therefore, a crucial problem is that, *in presentations of material, the persons who present it are not usually concerned about explaining the reasons for which they intervened in the way they did and the discussant is not interested in elucidating the presenters' reasons.* Consequently, what is produced is a dialogue of the deaf, who never meet on any shared ground, which thus leads to misunderstandings and a growing babelization.

I will now try to take a few steps towards the construction of a phenomenology of practice in psychoanalysis. Briefly, use of the phenomenological method means focusing carefully and reflectively on the way in which a reality appears to us, trying to parenthesize our prejudices (Jiménez, 2003). It is akin to viewing the analytic situation, as Freud used to say, *in statu nascendi*, which is to say in its original moment.

A useful way to approach a phenomenon is by exploring the original meaning of the words it denotes. The word 'practice', present in all European languages, comes from the Greek '*praxis*' and means not only action, act, activity, exercise, execution and realization, but also a way of working, a way of being, a result or consequence. Hence, something 'practical' is precisely something 'that works', is active or effective (Mendizabal, 1959). Owen Renik (2006) chose the last meaning in his book, *Practical Psychoanalysis for Therapists and Patients.* For Renik, in a *practical* psychoanalysis patients are able to revise with the analyst the way they construct reality, with the result that they feel better. I would like you to remember this definition later, when we examine the so-called *Junktim* thesis, which is an inseparable union between achievement of knowledge and the cure in psychoanalysis.

We will take one step more and try to place ourselves in the 'here and now' of the analyst's situation with the patient, comparing this situation to that of a supervision. During a supervision we look at events after they have occurred; therefore, it is natural for us to wonder why they occurred. What we are seeking then is an explanation. This is the moment inherent to psychoanalytic theories in terms of explanatory reasons. However, if we place ourselves in the situation in which they are happening, that is, in the analyst's

[3]Of course, supervising does not necessarily mean seeing someone else's material from the viewpoint of the official and public theories preferred by the supervisor. Imre Szecsödy, the Hungarian–Swedish psychoanalyst, developed a method of analytic supervision with a strong empirical base; it aims to create a situation of *mutative learning* in the relation with the supervisee, in which the latter learns to recognise the *system of interaction* established with the patient (Szecsödy, 1990).

place at the moment when he or she is interacting with the patient, the task is clearly not so much to explain as to predict, that is, to determine what will happen in the future: how the patient will react if the analyst intervenes in such and such a way. The task of prediction requires practical reasons rather than theoretical ones.[4] Practical reasons seek to answer, based on a series of alternatives – none of which has yet been realized – which is the best, in terms of what needs to be done. These are therefore not issues of fact and their explanation but issues of value: of what it is preferable to do.

During the session, the analyst's mind moves back and forth continually from theoretical reasons that, like partial minitheories, enable the analyst to understand and explain the interaction of the moment in terms of knowledge acquired in the course of the process to practical reasons, which orient decision-making in relation to what to say and when and how to intervene. If we look at material from a sequence of sessions, we are certain to find confirmation or refutation of predictions made by the analyst during one particular session. This is, however, something that does not correspond to the reality of the moment in question, since it is not a matter of finding explanations *ex post facto*, but of risking predictive hypotheses about something that has not yet occurred. In practical reasoning, the agent tries to evaluate and weigh reasons for acting, to compare what is speaking in favour of or against the alternative courses of action opening up. Further, this decision is definitely made in the first person, which is to say from a subjective viewpoint, in terms of the subject's predicament at that time. Thus, the decision to intervene bears all the singularity of an encounter with another in the *here and now*. This is an ideographic, creative and ineffable moment when the analyst takes a risk that, as a question of principle, can never be totally encompassed by explanatory theory. It is, so to speak, a moment 'empty' of theory.

Nevertheless, when we go beyond appearances, this is not really a moment 'empty' of theory. In it, the analyst uses primarily non-conscious theoretical–practical knowledge and applies it unawares. Twenty-five years ago, Joseph Sandler pointed out that:

> with increasing experience the analyst, as he grows more competent, will preconsciously (descriptively speaking, unconsciously) construct a whole variety of theoretical segments which relate directly to his clinical work. *They are the products of unconscious thinking, are very much partial theories, models or schemata, which have the quality of being available in reserve, so to speak, to be called upon whenever necessary.* That they may contradict one another is no problem. They coexist happily as long as they are unconscious.
>
> (Sandler, 1983, p. 38, my italics)

If this is so, then analysts, like neurotics, are not 'rulers in our own castles'; we work with our patients without knowing quite well how we do it.

[4]The difference between theoretical reasons and practical reasons is an old philosophical issue dating back to Aristotle. They differ by virtue of the character of their aims; practical reason is stimulated by the object of appetite. The Scholastics followed tradition by differentiating speculative reasons from operative reasons, a difference Kant takes up when he emphasizes that the two reasons, theoretical and practical, are not two different types of reason but the same reason whose application differs (see José Ferrater Mora, 1969).

An important part of analytic work, if not the most important, takes place on the implicit level. Victoria Hamilton (1996) reminds us that "even the more consistent thinkers practice inconsistently and in ways that are personal and idiosyncratic" (p. 317). The foregoing has important consequences for clinical discussion, since the person who discusses tends to do it based on personal, explicit explanatory theories, that is, official and public theories, while the person presenting material probably does not fully perceive, much less communicate, the practical, implicit reasons leading him or her to intervene in such and such a way. Of course, this situation can only block any chance of constructive clinical dialogue.

It is probably one of the reasons why the tradition of supervising during clinical discussions fails to grasp the essence of the analyst's work with the patient. The singularity of the therapeutic relation is constructed out of interwoven predictions and validations (or refutations) that constitute a dialogue between analyst and patient. In this sense, it is useful to think about analytic work as a craft. A craftsperson tends to use limited quantities of materials and theoretical–practical instruments to create works. Similarly, the analyst uses heterogeneous information accumulated during training and experience, which needs to be adapted creatively to each concrete case. In our psychoanalytic craft, as a norm, we use pre-existing materials (working models, partial theories and schemata). The combination of evenly suspended attention and free association facilitates moment to moment, spontaneous evocation of these models in dyadic interaction. Work is guided by the analyst's theories or meta-models concerning the 'best way' to psychoanalyse. In sum, I am describing the constructivistic nature of clinical work in which the analyst utilizes materials of diverse origins and types (Jiménez, 2008). For Canestri:

> The quantity of elements of every type and origin that contribute to the construction of these 'theories' or partial models are not to be underestimated. Among these elements are the specific contents of the analyst's unconscious and preconscious, his *Weltanschauung*, the psychology of common sense, his connection to a psychoanalytical group or school, the quality of this connection and the relationship he has with the psychoanalytic 'authorities', his scientific and pre-scientific beliefs, his personal re-elaboration of the concepts of the discipline, countertransference, etc. […] If due account is taken of the specificity of clinical practice, it can be seen that concepts in psychoanalysis are never formed once and for all, but are in continuous transformation and re-elaboration.
>
> (Canestri, 2006, p. 13f)

Even so, I think that the patient's role in this process of 'continuous transformation and re-elaboration' of concepts has been underestimated. Here we are considering the issue of intersubjective heuristics, that is, the role that we attribute to interaction between two minds working together. I am suggesting that, in the analyst's mind, a continual process of decision-making, with a background of 'implicit use of explicit theories'[5], is

[5]'Implicit use' refers to a decision-making process determined by practical reasons that evaluate the value of use or *usefulness* of explicit theories at a certain moment. In this case, the guiding question is not *why* but *for what purpose.*

constantly influenced by the patient's actions and reactions. In the course of this interaction, processes of validation or refutation of the analyst's interventions take place.

I said that analytic work is guided by the analyst's theories or meta-models concerning the 'best way' to psychoanalyse. We now need to examine more closely what we mean by the 'best way to analyse', which leads us to the diverse ways we may conceive of the psychoanalytic theory of change.

The core theory of therapeutic change in clinical practice

As Thomä and Kächele (1987) pointed out so aptly, the core of the causal conception of the theory of therapeutic change in psychoanalysis is formulated by Freud in the *Postscript to The Question of Lay Analysis* (Freud, 1927a):

> In psychoanalysis there has existed from the very first an inseparable bond [*Junktim*] between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results. Our analytic procedure is the only one in which this precious conjunction is assured. It is only by carrying on our analytic pastoral work that we can deepen our dawning comprehension of the human mind. This prospect of scientific gain has been the proudest and happiest feature of analytic work.
>
> (p. 256)

Ursula Dreher (2000) pointed out that, while in Freud's day this conjunction of cure and investigation may not have been problematic, today's views require an elaboration of this hypothetical union. However, leaving aside the controversy concerning what we mean by research, it is possible to describe important differences in the ways in which psychoanalysts in clinical practice have conceived of the union between gain of knowledge and cure. This issue is connected with the issue of goals or objectives in psychoanalytic therapy.

The history of psychoanalysis shows that there has never been much consensus on the objectives or goals of analytic treatment (Sandler and Dreher, 1996). Since Freud's time, the variety of opinions has ranged from the idea that psychoanalysis is a search for truth about the patient (Segal, 2006) to the view that its objective is to remove or decrease symptoms through more effective and better adapted compromise formations (Brenner, 1982). In practice, there seems to be a polarization into two undesirable extremes: on the one hand what we call *furor curandi*, and on the other hand the handling of treatments that go on without any clearly established objectives. In this respect, Gunderson and Gabbard declare that: ''In our experience as consultants to other therapists and analysts, we have observed that endlessly meandering treatments are not rare. They are sometimes justified by drawing a distinction between 'analytic' and 'therapeutic' goals'' (1999, p. 694). Renik seems to agree when he states: ''Most clinical psychoanalysts offer […] a lengthy journey of self-discovery during which too much concern with symptom relief is considered counterproductive'' (Renik, 2006, p. 1).

Marilia Aisenstein warns us that the question – well known in French psychoanalytic circles – ''Does the cure come as a byproduct of psycho-

analytic treatment?'' has often been attributed to Jacques Lacan: ''Lacan practically made an imperative out of this, originally Freud's idea: the psychoanalyst must not interest him- or herself in therapy; a position which has long influenced psychoanalysis in France'' (Aisenstein, 2003, p. 263). Even though Aisenstein insists that it is a mistake to separate therapeutic goal from psychoanalytic process, she corroborates that the search for truth is the basis of improvement in psychoanalysis. Of course, the idea that we need to search for the truth of the unconscious and that the cure will accompany it is a very widespread idea in psychoanalysis, not simply a legacy of French psychoanalytic tradition.

There is doubtless a broad consensus among analysts of the most diverse orientations that ''throughout a therapy, especially a successful one, a distinct sense of gradually finding and formulating a *truth* about the patient occurs'' (Strenger, 1991, p. 1, my italics). Hanna Segal put it this way: ''The kind of truth that concerns psychoanalysis is truth regarding psychic reality, regarding the functioning of the mind and its unconscious roots'' (Segal, 2006, p. 284). Divergence appears when we try to explain exactly what we mean by finding and formulating the truth about the patient. In this regard, differences are significant.

But even when we agree that it is a matter of seeking the patient's truth, who determines what the patient's truth is? How do we evaluate what the patient's truth is at any given moment? This is where the greatest concentration of divergent opinions and the greatest consequences for practice are produced. In the answer to these questions we identify two basic conceptions. On the one hand, a monadic conception that positions the analyst as an expert who 'knows best' how the patient's mind and its unconscious roots function, and on the other, a dyadic conception considering that truth is co-constructed in the interpersonal and intersubjective interaction between patient and analyst.

A phenomenology of practice in psychoanalysis does not support the monadic conception. Furthermore, I think that, in this conception, criteria to evaluate the 'functioning of the mind and its unconscious roots' tend to come from 'theories' in the analyst's mind more than from the patient's mind. The dyadic conception predisposes the analyst to listen more carefully to what the patient is seeking in the treatment: in general to feel better, even though many patients are assuredly seeking to do it by expanding their knowledge of themselves. Symptomatic relief thus becomes a guide in searching for the patient's truth. For Renik, ''many of the decisions which an analyst makes – what to investigate, how to intervene – should be determined by whether the patient is experiencing therapeutic benefit'' (Renik, 2006, p. 26). For Thomä and Kächele (2007, p. 662), ''the *junktim* is only satisfied if the 'beneficent effect' is proved''. For these authors, treatment reports, that is to say presentations of clinical material, need to focus on showing changes in the patient.

Even though the idea that the objective of psychoanalysis is to search for the truth of the unconscious did prevail for a long time, in recent decades ''a redefinition of the object of its study [is observed]; that is, the particular intersubjective figure constituted by the analyst–patient relationship''

(Canestri, 1994, p. 1079). In the latter sense, it is not possible to continue to separate exploration of the unconscious from what patient and analyst are attempting with this search, which goes beyond contemplation of the conjectured truth of the unconscious. To paraphrase Sandler and Dreher (1996), we cannot continue to ignore 'what analysts and patients want'. The search for the patient's truth does not happen in a void but in the midst of a relation between two persons, which leads us to deepen the subject of validation of the clinical context.

Validation of the clinical context, which is to say in the session with the patient, is an ongoing and inevitable process. As Tuckett (1994b, p. 1162) explains it: ''It is part and parcel of accepted analytic technique that we seek to amend our understanding and interpretation according to a constant subjective monitoring of the 'truth' of what we think is happening''.

In the perspective of validation of psychoanalytic work during the session, the classical criteria of truth, coherence, correspondence and usefulness of knowledge may be considered abstractions of a broad and unique process of validation, which includes *observation, conversation and interaction* (Kvale, 1995). If we want it to be applicable to psychoanalytic reality, we need to replace the classical idea of knowledge as a reflection of reality with a conception in which knowledge is a social and linguistic co-construction of intersubjective reality between patient and analyst. In the analytic situation, analyst and patient are continuously interpreting and negotiating the meaning of the relation, which becomes material for communication between them. Conversation becomes the ultimate context in which knowing must be understood (Rorty, 2000). Truth is constituted through dialogue and valid knowledge emerges as a result of interpretations and alternative and conflicting possibilities of action, which are discussed, negotiated and discerned in line with the rules of the psychoanalytic method.

In the clinical context, we are interested in the relation between meanings and acts, between interpretation and action. If we drop the dichotomy between facts and values, the issue of truth connects with aesthetics and ethics. In the case of a social construction, the beauty and use-related value of constructed knowledge move into the foreground. This turns us away from a psychoanalytic model based on archaeology, whose object is to discover a hidden truth, and towards an *architectural model,* for which it is construction of a new house that matters. Emphasis is thereby placed on pragmatic proof through action. The subject of the value of knowledge is no longer placed in a category separate from 'scientific' knowledge but is intrinsically joined to its creation and application.[6]

Validation in the analytic session is therefore a constant process of hypothesis- and conjecture-checking, of questioning and comparing them with theories and models available to the analyst at the time. In this process, the coherence of the analyst's own discourse becomes a criterion of valida-

[6]Peter Fonagy recently expressed similar ideas: ''Psychoanalytic theory, like any other theory, unconsciously serves to organize action. The truth of a theory is thus no longer seen as something absolutely entailed within the relation to an external reality. Rather, validity of a theory rests in its capacity to enable action. Knowledge is not an awareness of absolute facts, but the capacity to attain a goal within a specific context or setting'' (Fonagy, 2006, p. 83).

tion. However, validation also means checking knowledge with the patient. Through dialogue, analyst and patient reach a consensus or limit their differences regarding what they observe and what they consider 'clinical facts' and their meaning.

However, consensus on knowledge regarding observations and their meanings is only one part of validation in the clinical context. Pragmatic validation of interpretations transcends communicative validation. The interest guiding practical reasons for helping patients to make the desired change is intrinsic to the therapeutic enterprise. For Freud, one of the distinctions of psychoanalysis is precisely that investigation and cure go hand in hand. While communicative validation includes an aesthetic aspect, pragmatic validation involves the ethical dimension. For Freud, communicative validation was not enough; for him, a patient's 'yes' or 'no' to the therapist's intervention was never sufficient confirmation or invalidation. He recommended more indirect types of validation, through observation of changes in the patient's behaviour following the interpretation, such as changes in associations or dreams, emergence of memories or an alteration of symptoms. For Ricoeur, ''the therapeutic success […] constitutes […] an autonomous criterion of validation'' (1977, p. 868). Narrative truth constructed in the therapeutic encounter, bearing the conviction of a 'good history', needs to be judged as much for its aesthetic value as for the curative effect of its rhetorical force (Spence, 1982).

Briefly: a review of processes of validation in the clinical situation leads us to conclude that the effort of understanding clinical material, one's own and the other's, should consist primarily in discovering practical reasons underlying the analyst's interventions and their relation to changes observed in the patient.

Beyond an 'inseparable bond': Studying practice in its own merits

Following this outline of a phenomenology of practice in psychoanalysis, we will now review the theory of therapeutic change. In this section, I will take a step further and question the central core of the psychoanalytic theory of change. I assert that the *Junktim* idea that in psychoanalytic treatment 'knowledge brings success and it is not possible to treat a patient without discovering something new, nor is fresh insight gained without the perception of its beneficent effect' can no longer be supported as a universal truth. Although I am not unaware of the gravity of this statement, I am convinced that the *Junktim* idea does not do justice to the reality of the practice of psychoanalysts nor to current knowledge of mechanisms of therapeutic change. I risk challenging such a central thesis in Freud's thinking by basing my proposal on his own words when, referring admiringly to Charcot, he wrote that he ''never tired of defending the rights of purely clinical work, which consists in seeing and ordering things, against the encroachments of theoretical medicine'' (Freud, 1893f, p. 13). In his obituary on Charcot, Freud recalls the day when one of his students asserted that a certain clinical fact could not be true, since it contradicted the theory. Charcot shot

back immediately: ''So much the worse for the theory, clinical facts come first''. At the end, he expressed a thought that vividly impressed the young Freud: ''*La théorie c'est bon, mais ça n'empêche pas d'exister*'' [''Theory is fine, but it does not prevent existence''] (p. 13).

To my knowledge, the first person who explicitly restricted the scope of the idea of inseparable union between gain of knowledge and the cure was a Latin American psychoanalyst. José Bleger, in his posthumous paper of 1971, *Criterios de curación y objetivos del pscoanálisis* [Criteria of the cure and objectives of psychoanalysis], observed that not infrequently ''patients benefit from psychoanalytic treatment without having been cured of what they wanted to cure. […] In other cases, [he says] it is considered good progress and a good end of treatment (when nothing else can be achieved) if patients recognise and accept their symptoms, errors, limitations and difficulties. That is, they attain … objectives or effects of self-knowledge rather than curative ones'' (Bleger, 1973, p. 79).

Naturally, clinicians are also familiar with the opposite case: patients in whom the amount of self-knowledge acquired in the process does not do justice to the range of symptomatic and structural changes achieved. The Boston study group on the process of change (PCSG, 1998; Stern, 2004) offers an explanation for this clinical fact. They proposed a model of change in psychoanalytic therapy which considers that the therapeutic effect of the analyst–patient relationship resides in intersubjective and interactive processes leading to what they call *implicit relational knowledge*. This is a non-symbolic field unlike declarative knowledge, which may be explicit, conscious or preconscious and is represented symbolically in a verbal or imaginary manner. Historically, the theory of therapeutic change centred more on interpretation of intrapsychic dynamics represented on the symbolic level than on implicit rules governing the person's own commitments with others. These rules are not conscious but are inscribed in long-term procedural memory. The different moments of interaction between patient and therapist take shape in a sequential process oriented by verbal exchange, which may include a variety of interventions. The mutative locus in therapy is produced, however, when the movement of intersubjective negociation leads to *moments of meeting* with shared understanding of the implicit mutual relationship, producing in turn a recontextualization of the patient's implicit relational knowledge. These are moments between patient and analyst of reciprocal recognition of what is in the other's mind concerning the actual nature and state of the mutual relationship. This mutual recognition leads patient and analyst into a domain transcending this 'professional' relation without cancelling it and, in so doing, frees them partially from tonalities of the transference–countertransference relation. This shared knowledge may subsequently be validated consciously. However, it may also remain implicit.

The model proposed by the PCSG does certainly need to be validated. I consider that the clinical and empirical meaning of what they call a 'moment of meeting' is unclear. However, what is clear is that the ideas of the Boston group go beyond the core of psychoanalytic theory of change and aim at the role of the quality of the intersubjective relationship or so-called therapeutic alliance as an independent curative factor in therapy. The

truth is that the value of the patient's experience of the analyst as a prognostic element and curative factor has been recognized since Ferenczi's time. However, its position in the theory of change has never been comparable to the status of interpretation and insight and it continues to be a controversial issue in contemporary psychoanalysis. The following quote from a recent paper by Hanna Segal proves it:

> The Middle Group […] established a new model of the mind, deriving from Ferenczi and developed by Balint, Winnicott, and, later in the United States, by Kohut. The fundamental difference between this model and those of Freud, Klein, and their followers lay not in the fact that it took into account new clinical evidence, but rather in the kinds of uses it made of clinical evidence. A new concern emerged which focused on various notions of cure and change that did not rest on attaining truth and that considered the personal influences of the analyst […] to be integral to the analytic process. Here the changes in technique were of a kind that made them essentially nonanalytic. They went against the psychoanalytic effort to bring about change through the search for truth.
>
> (Segal, 2006, p. 288f)

Although the quality of the relationship as a factor of therapeutic change certainly does not pertain to the core of the theory of cure, we should answer this point with Charcot: 'so much the worse for theory', since the findings of over 50 years of empirical research on process and outcome of psychotherapy support the idea that the quality of the therapeutic relation is the most powerful factor of change in any type of therapy, including the psychoanalytic. Specific interventions, in this case interpretation and gain of insight explain the smallest part of variance of treatment results (Jiménez, 2007; Wampold, 2001). From the clinical perspective, this means that techniques and interventions are not effective in themselves or by themselves. The weight of evidence endorses the idea that therapy is a professional relation in which the quality of the personal relation between patient and analyst is a key factor for increasing (or limiting) the impact of therapeutic procedures (Orlinsky and Ronnestad, 2005). Of course, this also means that the range of techniques applied by successful analysts is much broader than what official theory of technique prescribes.

In relation to this, Carlo Strenger is emphatic:

> The consequence of these facts for the question of the link between reconstructive truth and therapeutic effect seems to be the following. The relation between these two properties of interpretation is certainly not as clear-cut as Freud took it to be. *Reconstructive truth is neither a necessary nor a sufficient condition for therapeutic efficiency.*
>
> (Strenger, 1991, p. 140, my italics)

Specificity of psychoanalysis in the *real* practice of psychoanalysts has also been questioned by comparative psychotherapeutic research. Ablon and Jones (1998) have demonstrated that psychoanalytic treatments include diverse sets of interventions in which therapists, aside from applying strategies characterized as psychodynamic, also apply, to a significant extent, technical interventions usually associated with a cognitive–behavioural approach. In other words, the manner in which therapists with different ori-

entations handle treatments includes significant superposition of theoretical models assumed to correspond to different intervention strategies. These investigations are consistent with others (Goldfried *et al.*, 1998; Jones and Pulos, 1993) that found a broad superposition of psychoanalytic, interpersonal and cognitive–behavioural therapies. Of course, differences between these approaches were found; for example, cognitive–behavioural therapy promoted control of negative affects through the use of intellect and rationality combined with vigorous stimulation, support and reinforcement by therapists; psychoanalytic therapies, in contrast, placed the emphasis on evoking affects, bringing disturbing feelings to consciousness and integrating current difficulties into previous life experience, using the therapist–patient relation as an agent of change. Although these authors studied short-term therapies, we may assume that the superposition observed also exists in long-term and high-frequency psychoanalytic therapies, until we have data to affirm the contrary.

We are therefore confronting a new field that requires further research. For instance, it is not clear whether Sandler's ideas on implicit theories used by psychoanalysts, which Fonagy has termed the *implicit psychoanalytic knowledge base*,[7] are equivalent to the Boston group's implicit relational knowledge. A topic here, not yet fully clarified, indicates the relation between explicit, declarative and symbolic knowledge and implicit, procedural and nonsymbolic knowledge. The latter is enacted in nonverbal interaction and a large part of it probably *never* reaches explicit level (Jiménez, 2006).

In any case, new findings of systematic research in mind-related disciplines and in psychotherapy process and outcome validate a spectrum of technical interventions that, although they do not fall within the official psychoanalytic theory of change, seem to be applied privately by many analysts in their everyday work. Gabbard and Westen (2003, p. 826, original italics) suggested: "deferring the question of whether these principles or techniques are analytic and focusing instead on whether they are *therapeutic*. If the answer to that question is affirmative, the next question [they continue] is how to integrate them [officially] into psychoanalytic or psychotherapeutic practice in a way that is most helpful to the patient". For these authors, a modern theory of therapeutic action needs to describe both changes (treatment goals) and strategies that are probably useful for promoting these changes (techniques). We have come to a point, they add, where single-mechanism theories of therapeutic action, no matter how complex, are unlikely to prove useful. This is due to the variety of targets of change and the diversity of methods useful in effecting change in those targets as well as the variety of techniques aimed at altering different kinds of conscious and unconscious processes.

Finally, my line of argument throughout this presentation leads me to suggest that it is time to liberate practice from theory, so that we can study it on its own merits:

[7]"This […] reconstruction of theory has not yet taken place within the public theory of psychoanalysis. It is held in a somewhat mysterious, unexplored container of knowledge that one might call the *implicit psychoanalytic knowledge base*" (Fonagy, 2006, p. 83, original italics).

> If theory were decoupled from practice, technique might progress on purely pragmatic grounds, on the basis of what is seen to work. Psychoanalytic theory of mental function could then follow practice, integrating what is newly discovered through innovative methods of clinical work.
>
> (Fonagy, 2006, p. 70)

This proposal is methodological rather than epistemological, since a total separation between theory and practice is impossible. The idea is to give legitimacy to implicit minitheories, to give them a chance to surface and be expressed so that they can be studied in their own merits.

This research program is an extension of what Sandler formulated in his 1983[8] paper, since it integrates different kinds of modern research in disciplines of the mind (Jiménez, 2006). It is a question of constructing a new paradigm based on principles of methodological pluralism, which I believe could remove psychoanalysis from its secular isolation (Luyten, Blatt and Corveleyn, 2006). When I speak in terms of systematic investigation of practice, I refer both to empirical process and outcome research, as well as to the very new qualitative methodology introduced by the movement of scientific renewal of the *Working Party* (Canestri, 2006; Tuckett *et al.*, 2008).

I conclude this presentation with a hopeful message: the scientific initiative set in motion by the *European Psychoanalytic Federation* (Tuckett, 2002, 2003), which has enabled the movement of the *Working Party* to emerge, offers us a methodology for collective investigation of an important part of the field of the implicit in practice of psychoanalysis. It is highly significant for my line of argument in this paper to learn that the methodology used to discuss clinical material in the *Working Party* is based on respect for this fundamental rule: *Psychoanalysis is what psychoanalysts practice* (Sandler, 1982, p. 44), which means that "the presenter in each group is to be considered a psychoanalyst, whatever transpires" (Tuckett, 2007, p. 1051). My own experience as a presenter of clinical material during the European Federation Conference in March 2007 supports my conviction that we are witnessing a new beginning. I firmly believe that this novel way to approach psychoanalysts' practice will inaugurate a cultural change resulting in a revitalization of psychoanalysis.

Translations of summary

Versuch, die Praxis der Psychoanalytiker in ihrer Eigenständigkeit zu erfassen. Das eigentliche Ziel dieses Beitrags besteht darin, über die Hindernisse nachzudenken, die sich der vom Chicagoer Kongress gestellten Aufgabe, nämlich der Erforschung von Angleichungen und Unterschieden in der psychoanalytischen Praxis, entgegenstellen. Der Autor diskutiert zwei wesentliche Hindernisse. Erstens die epistemologischen und methodologischen Probleme im Zusammenhang mit der Theoriebildung in der Psychoanalyse und insbesondere den Umstand, dass es keine verlässliche Methode gibt, das, was Psychoanalytiker in der Privatsphäre ihrer Praxis wirklich tun, zugänglich zu machen. Er schlägt vor, die Theorie zumindest partiell abzutrennen und zu versuchen, die Praxis von Psychoanalytikern an und für sich, in ihrer Eigenständigkeit, zu betrachten. Im Anschluss daran skizziert er eine Phänomenologie der psychoanalytischen Praxis, welche zeigt, dass Analytiker in ihrer Arbeit mit Patienten stärker von praktischen als von theoretischen Erwägungen geleitet werden. Das heißt, ihre Interventionen sind eher

[8] "It is my firm conviction that the investigation of the implicit, private theories of clinical psychoanalysts opens a major new door in psychoanalytic research" (Sandler, 1983, p. 38).

Prognosen als Erklärungen. Weil diese praktischen Erwägungen in der analytischen Beziehung ständig mit Hilfe ihrer Auswirkungen validiert werden müssen, diskutiert der Autor das Thema der Validierung im klinischen Kontext der Kerntheorie therapeutischer Veränderung in der Psychoanalyse, das heißt die Bedingungen, die notwendig sind, um in der klinischen Praxis die These einer untrennbaren Verbindung zwischen Einsichtsgewinn und Heilung zu bestätigen. Der Autor beschließt seinen Beitrag mit einer Infragestellung der Crux der psychoanalytischen Theorie der Veränderung und behauptet, dass diese weder der Praxis der Psychoanalytiker noch den modernen Kenntnissen über die Prozesse und Mechanismen therapeutischer Veränderung gerecht wird. Abschließend postuliert er, dass wir die Praxis von der Theorie trennen müssen, um erstere in ihrem eigenständigen Wert und mit Hilfe vielfältiger Methoden, die von der systematischen Untersuchung bis zu der jüngst entwickelten Methode der Working Party reichen, untersuchen zu können.

Aprehender la práctica de los psicoanalistas en sus propios méritos. El objetivo central de esta presentación es reflexionar sobre los obstáculos que se oponen a la tarea que propone el congreso de Chicago, a saber, explorar las convergencias y las divergencias en la práctica psicoanalítica. El autor plantea dos obstáculos principales. Primero, los problemas epistemológicos y metodológicos que existen en la construcción de teoría en psicoanálisis y, sobre todo, la imposibilidad de acceder de manera confiable a lo que los psicoanalistas realmente hacen en la intimidad de su práctica. Propone separar, al menos en parte, la teoría de la práctica en psicoanálisis para así intentar aprehender la práctica de los psicoanalistas en sus propios méritos. En lo que sigue esboza una fenomenología de la práctica del psicoanálisis, donde descubre que, en su trabajo con el paciente, el analista se guía más por razones prácticas que por razones teóricas, es decir, sus intervenciones son más bien predicciones y no explicaciones. Las razones prácticas deben validarse permanentemente en la relación analítica por sus efectos, por lo que se ocupa del tema de la validación en el contexto clínico de la teoría nuclear del cambio terapéutico en psicoanálisis, a saber, de las condiciones que debe cumplir la práctica clínica para que se satisfaga la tesis de la unión inseparable entre logro de conocimiento e insight. Termina desafiando el núcleo de la teoría psicoanalítica del cambio, con el argumento de que ésta no hace justicia a la práctica de los psicoanalistas ni tampoco a los conocimientos actuales sobre los procesos y mecanismos de cambio terapéutico. Propone finalmente desacoplar la práctica de la teoría, para así estudiarla en sus propios méritos, es decir, de acuerdo con sus efectos en el paciente, a través de una pluralidad de métodos, que van desde la investigación sistemática hasta la reciente metodología de los Working Party.

Concevoir la pratique réelle du psychanalyste. Dans cet article, l'objectif essentiel de l'auteur est de présenter certaines de ses réflexions à propos des obstacles auxquels se heurte la tâche proposée par le Congrès de Chicago, à savoir l'étude des convergences et des divergences dans la pratique psychanalytique. Parmi ces obstacles, il en examine deux qui lui paraissent fondamentaux. D'abord, les problèmes épistémologiques et méthodologiques liés à la construction d'une théorie en psychanalyse, notamment en raison de l'impossibilité à rendre compte de manière fiable de ce que fait le psychanalyste réellement dans l'intimité de sa pratique. L'auteur se propose d'isoler, au moins en partie, la théorie psychanalytique de sa pratique dans une tentative de saisir la pratique du psychanalyste telle qu'elle se présente. Ensuite, il esquisse une phénoménologie de la pratique psychanalytique qui montre que, dans son travail auprès de ses patients, le psychanalyste se laisse guider par des raisons davantage pratiques que théoriques; en d'autres termes, ses interventions sont plutôt des prévisions que des explications. Puisque ces raisons pratiques doivent constamment être validées dans la relation analytique à partir de leurs effets, l'auteur étudie la notion d'évaluation dans le contexte clinique de la théorie de base du changement thérapeutique en psychanalyse : dans quelles conditions la pratique clinique pourra-t-elle satisfaire aux exigences de la notion du lien indissociable entre mieux se connaître et guérir ? L'auteur tire la conclusion que la base même de la théorie psychanalytique du changement doit être mise en cause; à son avis, elle ne rend justice ni à la pratique du psychanalyste ni à ce que nous savons aujourd'hui des processus et des mécanismes du changement thérapeutique. Enfin, il nous invite à séparer la pratique de la théorie afin d'étudier celle-là à partir de ce qu'elle est réellement, en nous servant d'une pluralité de méthodes, depuis l'investigation systématique jusqu'à la méthodologie plus récente du Groupe de Travail.

Comprendere i meriti della pratica della psicanalisi. L'obiettivo centrale di questa presentazione è di riflettere sugli ostacoli presenti nel compito proposto dal Congresso di Chicago, che è quello di esplorare le convergenze e le divergenze della pratica psicanalitica. L'autore discute i due principali ostacoli. In primo luogo, i problemi epistemologici e metodologici relativi alla costruzione di una teoria psicanalitica e, in particolare, l'inaccessibilità, sotto qualsiasi punto di vista affidabile, di ciò che gli psicanalisti fanno davvero nell'intimità della loro pratica. Egli propone di separare, almeno in parte – nell'ambito della psicanalisi – la teoria dalla pratica, nel tentativo di comprendere i meriti della pratica psicanalitica. In seguito, egli traccia una fenomenologia della pratica della psicanalisi la quale rivela che, nel lavoro con i pazienti, gli analisti sono guidati più da ragioni pratiche che teoriche; cioè, i loro interventi sono previsioni piuttosto che spiegazioni. Poiché queste ragioni pratiche devono essere constatemente convalidate nella relazione analitica basata sui loro effetti, l'autore discute l'argomento della convalida nel contesto clinico della teoria fondamentale del cambiamento terapeutico nell'ambito della psicanalisi, e cioè le

condizioni necessarie nella pratica clinica per soddisfare la tesi di un'unione inseparabile tra acquisizione di conoscenza e cura. L'autore conclude contestando l'essenza della teoria psicanalitica del cambiamento, sostenendo che essa non rechi giustizia né alla pratica psicanalitica né alla conoscenza contemporanea dei processi e dei meccanismi di cambiamento terapeutico. Infine, egli propone il distacco tra pratica e teoria, al fine di studiare i meriti della prima utilizzando una pluralità di metodi che vanno dall'indagine sostematica alla recente metodologia del Working Party.

References

Ablon JS, Jones EE (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive–behavioral therapy. *Psychother Res* **8**:71–83.

Aisenstein M (2003). Does the cure come as a byproduct of psychoanalytic treatment? *Psychoanal Q* **72**:263–73.

Bernardi R (1989). The role of paradigmatic determinants in psychoanalytic understanding. *Int J Psychoanal* **70**:341–57.

Bernardi R (2002). The need for true controversies in psychoanalysis: The debates on Melanie Klein and Jacques Lacan in the Rio de la Plata. *Int J Psychoanal* **83**:851–73.

Bernardi R (2003). What kind of evidence makes the analyst change his or her theoretical and technical ideas? In: Leuzinger-Bohleber M, Dreher AU, Canestri J, editors. *Pluralism and unity? Methods of research in psychoanalysis*, 125–36. London: IPA.

Bernardi R (2005). What after pluralism? Ulysses still on the road. *Psychoanal Inq* **25**:654–66.

Bleger J (1973). Criterios de curación y objetivos del psicoanálisis. *Rev Psicoanál APA* **30**:317–42.

Brenner C (1982). *The mind in conflict*. New York, NY: International UP.

Canestri J (1994). Transformations. *Int J Psychoanal* **75**:1079–92.

Canestri J (2006). *Psychoanalysis from practice to theory*. Chichester: Wiley.

Canestri J, Bohleber W, Denis P, Fonagy P (2006). The map of private (implicit, preconscious) theories in clinical practise. In: Canestri J, editor. *Psychoanalysis: From practice to theory*, 29–44. New York, NY: Wiley.

Dreher U (2000). *Foundation for conceptual research in psychoanalysis*. (Psychoanalytic Monograph.) London: Karnac.

Etchegoyen H (1986). *Los fundamentos de la técnica psicoanalítica*. Buenos Aires: Amorrortu.

Ferrater Mora J (1969). *Diccionario de filosofía*. Buenos Aires: Editorial Sudamericana.

Figuera SA (1994). Toward the dissection of the psychoanalyst's mind: The psychoanalytic technical superego. In: *The analyst's mind: From listening to interpretation*, 31–41. London: IPA.

Fonagy P (2006). The failure of practice to inform theory and the role of implicit theory in bridging the transmission gap. In: Canestri J, editor. *Psychoanalysis: From practice to theory*, 69–86. Chichester: Wiley.

Freud S (1893f). Charcot. SE **3**, 7–23.

Freud S (1927a). Postscript to *The question of lay analysis*. SE **20**, 251–8.

Freud S (1933a). *New introductory lectures on psycho-analysis*. SE **22**, 1–182.

Gabbard GO, Westen D (2003). Rethinking therapeutic action. *Int J Psychoanal* **84**:823–41.

Goldfried MR, Raue PJ, Castonguay LG (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive–behavioral and psychodynamic–interpersonal interventions. *J Consult Clin Psychol* **66**:803–10.

Gunderson JG, Gabbard GO (1999). Making the case for psychoanalytic therapies in the current psychiatric environment. *JAPA* **47**(3):679–704.

Hamilton V (1996). *The analyst's preconscious*. Hillsdale, NJ: Analytic Press.

Jiménez JP (2003). A psychoanalytical phenomenology of perversion. *Int J Psychoanal* **85**:65–82.

Jiménez JP (2005). The search for integration or how to work as a pluralist psychoanalyst. *Psychoanal Inq* **25**:602–34.

Jiménez JP (2006). After pluralism: Towards a new, integrated psychoanalytic paradigm. *Int J Psychoanal* **87**:1–20.

Jiménez JP (2007). Can research influence clinical practice? *Int J Psychoanal* **88**:661–79.

Jiménez JP (2008). Theoretical plurality and pluralism in psychoanalytic practice. *Int J Psychoanal* **89**:579–99.

Jones EE, Pulos SM (1993). Comparing the process in psychodynamic and cognitive–behavioral therapies. *J Consult Clin Psychol* **61**:306–16.

Kvale S (1995). The social construction of validity. *Qual Inq* **1**:19–40.

Luyten P, Blatt SJ, Corveylen J (2006). Minding the gap between positivism and hermeneutics in psychoanalytic research. *JAPA* **54**:571–610.

Mendizabal R (1959). *Diccionario griego–español ilustrado*. Madrid: Razón y Fe.

Orlinsky DE, Ronnestad MH (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, DC: APA.

PCSG (1998). Non-interpretive mechanisms in psychoanalytic therapy: The 'something more' than interpretation. *Int J Psychoanal* **79**:903–21.
Pulver SE (1987a). How theory shapes technique: Perspectives on a clinical study. Prologue. *Psychoanal Inq* **7**:141–5.
Pulver SE (1987b). How theory shapes technique: Perspectives on a clinical study. Epilogue. *Psychoanal Inq* **7**:289–99.
Renik O (2006). *Practical psychoanalysis for therapists and patients*. New York, NY: Other Press.
Ricoeur P (1977). The question of proof in Freud's psychoanalytic writings. *J Am Psychoanal Assoc* **25**:835–71.
Rorty R (2000). Pragmatism. *Int J Psychoanal* **81**:819–23.
Sandler J (1982). Psychoanalysis and psychotherapy: The training analyst's dilemma. In: Joseph ED, Wallerstein RS, editors. *Psychotherapy. Impact on psychoanalytic training: The influence of practice and theory of psychotherapy on education in psychoanalysis*, 39–47. (International Psychoanalytic Association, Monograph 1.) New York, NY: International UP.
Sandler J (1983). Reflections on some relations between psychoanalytic concepts and psychoanalytic practice. *Int J Psychoanal* **64**:35–45.
Sandler J, Dreher AU (1996). *What do psychoanalysts want? The problem of aims in psychoanalytic therapy*. London: Routledge.
Segal H (2006). Reflections on truth, tradition, and the psychoanalytic tradition of truth. *AIM* **64**:283–92.
Seitz PFD (1966). The consensus problem in psychoanalytic research. In: Gottschalk LA, Auerbach AH, editors. *Method of research in psychotherapy*, 209–25. New York, NY: Appleton-Century-Crofts.
Spence D (1982). *Narrative and historical truth: Meaning and interpretation in psychoanalysis*. New York, NY: Norton.
Stern DN (2004). *The present moment in psychotherapy and everyday life*. New York, NY: Norton.
Strenger C (1991). *Between hermeneutic and sciences: An essay on the epistemology of psychoanalysis*. Madison, CT: International UP. (*Psychological Issues*, Monograph 59).
Szecsödy I (1990). *The learning process in psychotherapy supervision*. Stockholm: Karolinska Institut.
Thomä H, Jiménez JP, Kächele H (2006). Vergleichende Psychoanalyse – textnahe klinische Forschung (Comparative psychoanalysis: Textual clinical research). In: Thomä H, Kächele H, editors. *Psychoanalytische therapie. Forschung*, 177–98. Heidelberg: Springer.
Thomä H, Kächele H (1987). *Psychoanalytic practice. 1. Principles.* Heidelberg: Springer.
Thomä H, Kächele H (2007). On the basis of a new form of treatment report. *Psychoanal Inq* **27**:650–85.
Tuckett D (1994a). The conceptualization and communication of clinical facts in psychoanalysis. Foreword. *Int J Psychoanal* **75**:865–70.
Tuckett D (1994b). Developing a grounded hypothesis to understand a clinical process: The role of conceptualisation in validation. *Int J Psychoanal* **75**:1159–80.
Tuckett D (2002). The new style conference and devoloping a peer culture in European psychoanalysis. Presidential Address, Prague. *EPF Bulletin* **56**:2002.
Tuckett D (2003). *A* ten-year European scientific initiative. Presidential Address, *EPF Bulletin* **57**:2003.
Tuckett D (2006). The search to define and describe how psychoanalysts work: Preliminary report on the project of the EPF Working Party on Comparative Clinical Methods. In: Canestri J, editor. *Psychoanalysis: From practice to theory*, 167–200. Chichester: Wiley.
Tuckett D (2007). Wie können Fällen in der Psychoanalyse verglichen und diskutiert werden? Implikationen für künftige Standard der klinischen Arbeit [On the problem of comparing and discussing clinical material in psychoanalysis: Implications for future standards of clinical work]. *Psyche – Z Psychoanal* **61**:1042–71.
Tuckett D, Basile R, Birksted-Breen D, Böhm T, Denis P, Ferro A, Hinz H, Jernstedt A, Mariotti P, Schubert J (2008). *Psychoanalysis comparable and incomparable: The evolution of a method to describe and compare psychoanalytic approaches*. London: Routledge.
Wampold BE (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

