

Chapter 13  
Conclusion

“Life is short, and the Art is long; the occasion fleeting; experience delusive; judgment difficult” (Hippocrates – the first aphorism).

Freud’s fascination with neurosis as an opening into large vistas was captured by Sulloway (1979) who quotes Freud’s late remark: “With neurosis it is as though we were in a prehistoric landscape -- for instance, in the Jurassic. The great saurians are still running about; the horsetails grow as high as palms (1941f, S.E., 23:299)” (p.497).

Freud’s goal was to discover the cause of neurosis, and his treatment of patients was in the service of that goal -- as well as to enable him to earn a living. His theory of “transference” hypothesized that childhood experience and/or fantasy was the cause of the adult patient’s untoward feelings about the analyst as well as the predisposing cause of neurosis. This etiological theory of “transference” has never been validated and I have argued that it is not possible to validate it. Of course, failure to validate does not mean that it may not be true -- only that we don’t know. Freud believed that uncovering the predisposing cause was necessary for the successful treatment of neurotic patients. He was wrong. A great many medical disorders that are effectively treated are disorders whose cause is unknown. Patients are helped by analytic treatment without elucidating the cause. To what degree discovering the putative childhood cause of the patient’s feelings and fantasies about the analyst or of the patient’s neurosis is therapeutic remains controversial.

Indeed, Meehl (2001), in a recent letter to Grünbaum expresses skepticism that interpreting the putative cause has much therapeutic efficacy:

We might further decide, as a matter of technology, that uncovering them [the putative causes] is not the prime efficient cause of symptomatic improvement. ... I think any honest clinician who is not totally dogmatic becomes aware of the imperfect correlation – not zero, but certainly small – between the clarity with which an unconscious regnant process [cause] is elucidated with symptomatic benefit [Grünbaum, Personal communication, 2001].

Consider hypothetically that the dearth of maternal nurturing during childhood is actually, in some way, conclusively demonstrated to be the cause in an individual patient of some particular adult psychopathology. Does the specific identification of that childhood cause so inform the analyst’s interventions that the therapeutic benefit is significantly greater than if the cause had not been identified? More specifically, is it necessary to interpret the significance of childhood cause to the patient vis-à-vis the patient’s attitude toward the analyst? To me, it is not self-evident that it would be. It is not obvious that the patient would be better able to make the current changes via the analytic relationship necessary to reduce or relieve the psychopathology than he or she would if the childhood cause had not been identified. Thus, whether knowledge of the

childhood cause improves therapeutic benefit is itself an additional hypothesis which needs to be tested empirically. Treatment benefit would have to be examined in comparable samples of patients, comparing those in whom a cause had been identified with those in whom no cause had been identified. No such study has been reported, and, given the methodological and human complexities involved, it is unlikely such a study will be conducted. Therefore, we arrive again at the specific conclusion that the hypothesis that identification of a childhood cause enhances the therapeutic benefit of analytic treatment can neither be empirically tested nor validated.

Let us be clear that uncovering the predisposing cause and analyzing the “transference” are connected: Freud’s concept of “transference” embodies the goal of finding -- and confronting in situ -- the cause of neurosis. For a century Freud’s understanding has structured and focused analytic treatment on the patient’s feelings toward the physician as part of the exploration for the childhood origins of adult psychopathology. Recently, while some analysts have moved from the traditional, historical concept of “transference” to new ideas and techniques -- usually without coining a new term for the new conception -- this shift away from reconstruction toward analyzing current “transference” has occurred without explicitly discarding Freud’s theory of “transference.” In the history of psychoanalysis there have been three designated shibboleths: the Oedipus complex, the interpretation of dreams and now the theory of “transference” (Person, 1993); I assert that all three have lost their salience; the latter arguably has become less of a shibboleth and more of an albatross.

In this book I have proposed abandoning Freud’s overarching goal of discovering the cause of neurosis, giving up the search for the caput Nili and the pursuit of the Holy Grail. Rather, we should substitute the more modest goal of understanding how better to help patients, deliberately choosing to concentrate on psychoanalytic therapy rather than to develop further traditional psychoanalytic theory. My position contrasts with Rangell’s decrying of a separate “clinical theory” and an “abstract theory”. For where Rangell proposes a unified, composite theory of the science of psychoanalysis which is based on the analyst’s empirical observations and incorporates the metaphors of economic, topographical and structural theory, I suggest that the intrinsic complexity of the dyad limits the validity of many of the analyst’s observations as a basis for scientific generalizations, and that for the art of psychoanalytic treatment the analyst’s idiosyncratic theory and personal emotional reactions to the patient offer a sounder guide. One by one the value of Freud’s critical theories has been questioned; his theory of the death instinct was never well accepted (Cooper, 1987), economic (libido) theory (Kardiner, Karush and Ovesey, (1959), topographic theory (Arlow and Brenner, 1964), structural theory (Brenner, 1994, 1998) and theory of regression (Inderbitzin and Levy, 2000); and now the theory of “transference” as well.

If psychoanalysts decide to put aside traditional psychoanalytic theory in favor of a truly revised understanding of psychoanalytic treatment, who is to say that that treatment is or is not psychoanalysis? We should attempt to focus on treatment in accord with the views of G. Klein and Gill, without any standard theory of mind, relying only on the personal, covert, idiosyncratic theory of each analyst, which, to be sure, is inescapable. I disagree with Crews (2000) who, like Grünbaum, faults Freud for not being appropriately scientific and then adds, therefore, his work is of limited value: “A Freud

whose ideas cannot be considered within their intended domain of psychological theory is no Freud at all” (Crews, p.101).

In the treatment domain, Freud’s descriptions of the interactions of unconscious dynamic mechanisms such as defenses greatly facilitate understanding the patient’s feelings and meanings. Freud’s characterizations of defenses are independent of postulating any distal, childhood cause, even though defenses may play a proximal, causative role in the here-and-now.

The therapeutic goal, in Cooper’s (1987) terms, is to enable “a sufficient reorganization of ego capacities ... so that there is a greater coherence of conscious and unconscious elements” (p.146). Arlow’s (1987) characterization of the therapeutic goal is “the successful resolution of conflict, rather than the recovery of repressed memory” (p.76). Our conduct should be guided by Mitchell’s (1997) recommendation that the analyst rely on “self-reflective responsiveness,” supplemented by a pragmatic set of clinical procedures, such as those suggested by Ehrenberg (1992), which include monitoring the affectivity of both participants and giving priority to analyst-patient interactions in the here-and-now. Gedo (1999) notes that Ehrenberg deals with clinical psychoanalysis as an art rather than as applied science. As do I. Gedo’s opinion is that her approach scarcely adds up to a psychoanalytic theory: “It is at best a more or less coherent list of pragmatic guidelines for conducting the treatment in a humane atmosphere and hoping for the best” (p.209). Precisely so.

I do think clinical psychoanalysis is not science but art, in the sense that each psychoanalytic treatment is a function of the idiosyncratic values, feelings and fantasies, conscious and unconscious, of each member of the dyad and therefore is not replicable. Kantrowitz (1993) argues that “the quality of each patient-analyst match creates a unique, non-replicable treatment experience” (p.894), and adds that “Differences between what emerges in one treatment and what might have emerged from another can never really be tested” (p.902). Psychoanalysis as an art is difficult to learn, and almost impossible to teach. Kerr (1994), too, considering the failure to generate homogeneous results in the early history of the psychoanalytic movement, soberly concludes, “Whatever it is, psychoanalysis is not a science” (p.509). Green (2000a) also concurs that “the specificities of its practice and of its mode of thinking were not compatible with the ordinary requirements of scientific evidence” (p.22). He adds (2000c) that the so-called scientific “method” seems very unscientific “because of its irrelevance to the object of psychoanalysis” (p.66). Fairfield (2001) makes the same point: “For postmodernists, then, an epistemology in which an objectively real external phenomenon can be observed in an unmediated fashion by a neutral researcher is not suitable when it comes to the psyche” (p.234).

Conceiving of psychoanalytic treatment as art isn’t inappropriate once we recognize -- and accept -- that each analyst’s treatment is influenced by his or her own values and personality (Aron, 1999, Kantrowitz, 1995). “The art of psychoanalytic technique,” writes Westen and Gabbard (2001), lies as much as anything in the art of selecting, from among the thousands of points of entry in any given hour, material that is likely to go somewhere, that is, to have some import more broadly for the patient’s life” (p.29). Canestri (1994) believes “that the activity of the analyst is very close to that of the artist” (p.1079). He quotes Freud (1911) as characterizing the artist as a person who turns away from reality to fantasy, but finds his or her way back to reality “by making use

of special gifts to mould his fantasies into truths of a new kind, which are valued by men as precious reflections of reality” (p.224). But can this not also be said of analytic reflection, with the result being new understandings of the patient? Sandell, Blomberg, Lazar et al. (2000) noted in an outcome study that therapists who considered psychotherapy as “more a work of art than a craft or science” (p.933) had better patient outcomes.

Nor is it surprising that we have not agreed which elements of treatment are mutative, since they probably vary with each dyad. The best predictor of favorable outcome (Luborsky, 2000) is the early therapeutic alliance, marked by the patient’s positive feelings about the therapist. Moreover, supportive, non-interpretive interventions, plus “transference” interpretations, varying in content with different psychoanalytic schools, all seem helpful. Although plausible historical interpretations and narrative constructions may appear to produce impressive, even dramatic therapeutic reactions, I believe the role of suggestion and of placebo effects cannot be ruled out in the impact of those experiences.

Strikingly, Freud notes that “the patient’s conviction of the truth of the reconstruction achieves the same therapeutic result as a recaptured memory” (1937a, p.266)! I believe that psychoanalysis has not demonstrated that its help has been delivered through anything other than a non-specific effect -- nor has any other therapeutic technique. Delineation of mutative factors remains a major challenge. Examining and understanding non-specific effects, rather than not attending to them, may well enhance our therapeutic effectiveness.

Green (2000b) does raise a question whether if one’s point of view about psychoanalysis “is not scientific then one has to be -- whether one likes it or not -- a hermeneuticist” (p.46). Though Green’s comment has merit, let me leave that aside and grant that my proposal puts me in bed with the hermeneuticists even though I am a natural scientist at heart, having spent years engaged in quantitative, biological research. Traditional psychoanalytic theory is criticized for attempting causal explanations unsuccessfully; hermeneutics is criticized for not attempting causal explanations. Grünbaum (1990) strongly endorses Freud’s search for causal explanations, which, in their turn, become the main target of Grünbaum’s critique. Eagle (1986) joins Grünbaum in faulting analysts for failing to meet this imposing theoretical goal, “to think clearly and fruitfully about how human behavior can be meaningfully explained” (p.232). Eagle adds, “The programmatic aim of hermeneuticians seems to be nothing less than to render human behavior exempt from causal accounts and scientific explanation” (p.231).

The problem with regard to causal explanations is similar to that in relation to inherited biological predispositions. As Peskin (2000) points out, the necessary quest for integration with neighboring sciences leads us “to a reconfrontation with the old ghosts of biological disposition and instincts ... which still roam, unburied, in the labyrinthine halls of mind for the sound reason that they are not dead” (pp.230-231). While these biologic predispositions influence the patient’s behavior, they are impossible to delineate at this time, and must be held in abeyance for lack of clinical relevance, though some day they will be important in research into etiology. Medication aside, I know of nothing in natural science that can inform the choice of interventions in a clinical analytic situation.

Psychoanalytic hermeneutics does eschew all causal explanations, not in any attempt to oppose the unity of natural and human sciences (Grünbaum, 1999), and not

because there are neither facts nor causes in relation to psychoanalysis, but because they are unascertainable. Eagle (1986) again supports Grünbaum's telling critique of psychoanalysis for failing to be accountable for assessing the efficacy of analytic treatment. Whether analytic treatment is more effective than other forms of treatment can be determined only by scientific testing, but there are daunting, perhaps insurmountable human and methodological difficulties in doing such testing (Edelson, 1986).

No satisfactory controlled study, as called for in principle by Grünbaum and Eagle, of the effectiveness of analytic treatment in comparison to other treatments and to no treatment, has ever been conducted. How could persons be assigned randomly to psychoanalytic treatment, to no treatment and to a placebo, and their participation assured for a number of years? How do you manualise psychoanalytic treatment? In addition, how well can you measure a fantasy, or self-esteem? I agree with Mitchell (1993), Wolff (1998), Wallerstein (1999b), Green (2000b), Mosher (2000) and Sandell, Blomberg, Lazar et al. (2000) that it is not possible to conduct such a controlled study in the foreseeable future. How is a patient to select a therapist if psychoanalysis has not validated its effectiveness? Perhaps in the same way a person would select a portrait painter, or an architect. While outcome research has been informative, it has been unable to address the fundamental questions that require a truly controlled study. Psychoanalytic research has been fruitful. Indeed, certain questions can be answered only by empirical study. But I believe psychoanalytic research cannot address etiological problems; how well it will elucidate the mutative factors in analytic treatment remains to be seen.

I am not troubled that hermeneutics adopts an ahistorical attitude toward the patient. Grünbaum (2000), himself, proposes a resolution. Theoretically, the person's history can be eliminated "by encapsulating its cumulative effects in a sufficiently complex state-description of the human organism at one time" (p341). That is, only those registrations of past experience that are currently accessible, consciously or unconsciously, to the patient are relevant to the current situation; the vast remainder of registrations of the patient's history, since not accessible or available, are irrelevant to the here-and-now situation. Grünbaum's conception is congruent both with Lewin's field theory and with Sandler and Sandler's present unconscious.

Once the analytic practitioner focuses on helping the patient, developing theories of causality of human behavior, though haply it may occur, will manifestly be seen to be of lesser clinical utility. The development of theory, like the search for happiness, may only come to pass as a byproduct. Freud wrote, more elegantly than I can, in a letter to Ferenczi in 1915, (quoted by Gribinski, 1994) "I consider that one should not make theories. They should arrive unexpectedly in your house, like a stranger one hasn't invited" (see Grubrich-Simitus, 1985, p.113). As Friedman (2000) observes, the effectiveness of analytic treatment "reveals something about the nature of the mind" (p.257).

Analytic practitioners are left with only one pragmatic option at this time, to cobble together what I will designate as hermeneutics, for want of an alternate term, in which uncertainty colors all attempts to assess treatment effectiveness as well as all attempts to identify the causes of "transference," of psychopathology, or of therapeutic benefit. The uncontrolled, idiosyncratic, complex nature of the dyadic situation makes validating causes impossible. The analytic situation can be studied by scientists, but the difficulties inherent in such an effort, including the inability to measure subjectivity, to

evaluate the influence of chance or to assess the role of inherited biological factors in the individual, are likely to limit the fruitfulness of the results.

My impression is that analysts long have helped patients while hypothesizing causes that could not be and were not validated. The patient's reasons and meanings can become causes. What is useful about a hypothesized cause in treatment is not the question of its validity, but how we can understand whether it has a therapeutic impact, or, in Arlow's (1987) terms, "What is important is the dynamic effect of the interpretation" (p.84). My pragmatic adoption of a hermeneutic framework does not mean that I privilege narrative development among mutative effects.

What is left to guide analytic treatment if the theory of "transference" and its associated principles of technique are discarded? I think that many analysts, without explicitly disavowing the theory of "transference," or articulating a rationale have gradually modified their focus on putative childhood causes in favor of examining patient-analyst interaction in the here-and-now. However, it is my impression that this shift is mainly theoretical and only partial, and intermittently they reinvoke childhood experiences and fantasies as the origins of adult characteristics. Such explorations may not only divert the treatment from dealing with emotionally-charged patient-analyst interactions in the here-and-now, but blunt those critical moments.

"Transference" is so integrally connected to etiology that I have proposed an alternate concept, Habitual Relationship Patterns, which eschews any futile search for childhood causes. Habitual Relationship Patterns refers to persistent feelings and fantasies, conscious and unconscious, that shape our customary ways of relating to others. Analytic treatment examines the functions and meanings of those Patterns and especially the resistances that interfere with changing them to improve the person's ways of relating to others, especially to the analyst.

In examining these patterns, the analyst is guided by what Mitchell has described as the analyst's "self-reflective responsiveness," rather than by a standard theory. Essentially, this is all the analyst can do since the unavoidability of the influences of the analyst's idiosyncratic values and unconscious feelings and fantasies upon all interpretations and interactions is recognized. Consistently maintaining the focus on the affective patient-analyst interactions in the here-and-now, about which the analyst, as participant observer is uniquely informed, provides hope of enhancing the efficacy of analytic treatment.

The analyst interacts with the patient as sensitively, as empathically, as humanely as possible, substantially influenced by his or her own unconscious feelings and fantasies, while continually looking back trying to understand prior interactions -- knowing full well causes can never be identified with certainty. Without establishing verifiable causes, patients are nonetheless still helped to modify conscious and unconscious defenses. That is the art of psychoanalytic treatment. That art, like that of other artists, utilizes intuition and creativity, often originating in the accessible unconscious. The analyst, as artist, is as entitled to a fee for his or her services as other artists in our society. Granted, insurance companies are unlikely to reimburse for such services, but that is already largely the case.

Parenthetically, art and aesthetics are not as foreign to science as often they are conceived to be. Stone (2000) observes that "Art and beauty have always been about finding the universal in the particular" (p.51), and that universal is the stuff from which theories emerge.

The pragmatic, hermeneutic “solution” to the epistemological problems of psychoanalysis seems workable, though it is neither elegant nor scientifically satisfying. Neither is life. Lewis (2001), in an obituary for Nobel laureate Herbert A. Simon, describes his view of human decision making as “satisficing,” looking for a course of action that is satisfactory or ‘good enough.’

Does discarding the traditional theory of “transference” and its integral treatment goals undermine psychoanalysis, or, instead, constitute the beginning of an invigorating paradigm shift? Makari (2000) asserts that “changes in psychoanalytic theory can be read as adaptive ways for psychoanalysis to remain meaningful to a changing culture. ... for the most part as history moves, it is the dog, and psychoanalytic theory the tail being wagged” (p.259).

If the credibility of psychoanalysis rests upon its theoretical underpinning – a theory increasingly acknowledged to be indefensible -- abandoning the theory of “transference” might seem destructive. To the contrary, I think the credibility of psychoanalysis, both of the individual practitioner and of the profession as a whole, is based on its therapeutic efficacy. Those analysts who have successful, full practices are those skilful at helping patients, not those learned about psychoanalytic theory. Patients, the locus of credibility of psychoanalysis, have little interest in theory; they are concerned about being helped. While the structure of theory may, as Spence has noted, reassure some analysts, I assert that nothing can enhance the credibility of psychoanalysis as emphatically as increased therapeutic efficacy.

Mosher (2001), who read an earlier version of this Conclusion, found its implications were quite frightening: “It becomes more and more difficult to say what psychoanalysis is about. ... What is left of psychoanalysis other than a bunch of opinions about what is helpful from a disparate group of literate individuals?” But that is exactly where the current analytic treatment situation is. And that, I argue, represents a positive development in psychoanalysis. Limitations of knowledge require us to acknowledge that no extant, standard psychological theory uniformly applied to all patients is likely to be optimally helpful. Psychoanalysis is acknowledging that treatment is an art, best approached idiosyncratically.

Despite the fact that psychoanalysis cannot claim any specific distinguishing therapeutic effects it can claim to employ a distinguishing technique, namely, the intensive examination of conscious and unconscious feelings and fantasies of both patient and analyst that underlie their Habitual Relationship Patterns. I know of no other approach that utilizes such a technique. That technique, I propose, not the theory of “transference,” is the current shibboleth of psychoanalysis.

No single quotation can epitomize a person as multifaceted as Freud. One commentary by Stoppard, although not referring to Freud, I thought was remarkably apropos of one aspect of Freud:

He trusts to his felicity of instinct. When that fails him, no one can defend more stubbornly a plain corruption, or advocate more confidently an incredible conjecture, and to these defects he adds a calamitous propensity to reckless assertion [1997, p.34].

Nonetheless, Freud was one of the towering geniuses of the 20<sup>th</sup> century. Kardiner (1977) epitomized his accomplishments: Freud created a new conception of human nature by delineating the intrapsychic, complex, dynamic unconscious forces in the human mind.

Macalpine (1973) adds: “Today it is as impossible to think of psychiatry without the dynamic unconscious as it is to think of medicine without the circulation of blood” (p.137).

In closing I would like to quote two verses from Auden’s (1967) poem, “In Memory of Sigmund Freud.” The last phrase has become a commonplace but the lines preceding them also deserve our attention and assent:

If some traces of the autocratic pose,  
The paternal strictness he distrusted, still  
    Clung to his utterances and features,  
It was a protective coloration

For one who’d lived among enemies so long:  
If often he was wrong and, at times absurd,  
    To us he is no more a person  
Now but a whole climate of opinion.

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From the heady vantage point of Freud’s contributions, we have the challenging opportunity to apply the understanding Freud provided us of the dynamic mechanisms of the mind to enhance our capability to treat and help emotionally troubled persons. This goal, more modest than the one Freud chose, enhances rather than constrains the psychoanalytic enterprise; in Stephen J. Gould’s words: “The deflation of hubris is blessedly positive, not cynically disabling” (2001, p.A15). It is we who determine how surprising and exciting the development of psychoanalysis proves to be.

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