A brief history of psychoanalysis: From Freud to fantasy to folly

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The genesis of psychoanalysis

Psychoanalysis has had a long gestation, during the course of which it has experienced multiple rebirths, leading some current authors to complain that there has been such a proliferation of theories of psychoanalysis over the past 115 years that the field has become theoretically fragmented and is in disarray (Fonagy & Target, 2003; Rangell, 2006). In this paper, I survey the past and present landscapes of psychoanalytic theorizing and clinical practice to trace the evolution of Freud's original insights and psychoanalytic techniques to current theory and practice. First, I sketch the evolutionary chronology of psychoanalytic theory; second, I discuss the key psychoanalytic techniques derived from clinical practice, with which psychoanalysis is most strongly identified; third, I interrogate whether Freud's original theoretical conceptualizations and clinical practices are still recognizable in current psychoanalytic theory and practice, using four key exemplars – object relations theory, attachment-informed psychotherapy, existential/phenomenological and intensive short-term dynamic psychotherapy; and fourth, I discuss recent unhelpful, disintegrative developments in psychoanalytic scholarship. To this end, I critique the cul-de-sacs into which some psychoanalytic scholars have directed us, and conclude with the hope that the current state of affairs can be remedied.

Psychoanalysis is simultaneously a form treatment, a theory, and an "investigative tool" (Lothane, 2006, p. 711). Freud used each of these three facets of psychoanalysis iteratively to progress our understanding of human mental functioning. Among Freud's unique theoretical insights into the human condition was the historically new idea that humans are primarily animals driven by instincts (Freud, 1915a, 1920) who undergo growth via universal developmental (psychosexual) stages that are influenced by family and social life. This was in opposition to the prevailing view of his time that humanity was God's highest creation. Freud (1908) challenged the cherished belief that humankind is

rational and primarily governed by reason, replacing it with the disturbing notion that we are in fact driven by unacceptable and hence repressed aggressive and sexual impulses that are constantly at war with the "civilized" self.

Freud himself and Freud scholars (Jones, 1953; Strachey, 1955) consider that the Studies on Hysteria (Breuer & Freud, 1893) mark the beginning of psychoanalysis as a theory and a treatment. These early papers place the causes of the symptoms of hysteria firmly in the psychological, not the neurological domain (although such a distinction is no longer sustainable), thus moving thinking about the cause of hysterical and other psychological symptoms from the brain to the mind. This insight underpinned a paradigm shift in thinking about the mental functioning of human beings, for which there was a scant vocabulary and embryonic conceptualizations. The theory that organized early clinical observations gradually unfolded, many precepts of which have entered the psychological lexicon as givens, concepts that are now taken for granted. Three of these bedrock concepts are the existence of the Unconscious, the notion of hidden meaning and the idea of repression.

The Unconscious, hidden meaning, repression and the affect-trauma model

The central tenet of Freud's psychoanalytic theory is the concept of the unconscious, from which he derived two corollary concepts: hidden meaning and repression . The concept of repression is essential, not only to an understanding of the Unconscious but to psychoanalysis itself. Freud described it as the "cornerstone" of psychoanalysis (Freud, 1914g, p. 16) and viewed repression as "the prototype of the Unconscious" (Freud, 1923a). In fact, Freud viewed repression as the mental process that creates the Unconscious.

The aim of Freud's psychoanalysis was to support expression of the affect associated with a traumatic memory, a process later termed catharsis, and to bring the repressed trauma into conscious memory, a process called abreaction. The Unconscious refers to the existence of thoughts and feelings of which we are not aware that motivate our strivings and behaviour. It is the locus of dynamic psychic activity – the place where wishes, impulses and drives reside, a place not beholden to the realities of logic or time or the constraints of socially acceptable behaviour. The contents of the Unconscious are usually experienced as painful and/or forbidden and have therefore been repressed, that is, excluded from consciousness, in order to reduce the associated anxiety, guilt or conflict. Repression is a defence mechanism that keeps unconscious material out of conscious awareness. However, the excluded material continues to influence behaviour because it is so emotionally charged that it demands expression. Individuals express their repressed thoughts or feelings in subtle, symbolic or disguised ways, such as in dreams, slips of the tongue, jokes, and symptoms – manifestations that Freud called "the return of the repressed" (Freud, 1915b, p. 148), a process that today is called enactment (Cambray, 2001; Chused, 2003; Eagle, 1993; Friedman & Natterson, 1999; Ivey, 2008). The hidden meaning of symptoms must be uncovered and consciously re-experienced, together with their associated affect in order to effect a "cure." This was the first of Freud's models of the functioning of the mind that became known as the affect-trauma model, a model that resonates strongly with current psychoanalytic approaches that

address early relational trauma through a holding therapeutic relationship that resembles the mother-infant dyad (Holmes, 2011).

Freud's theorizing was greatly affected by his observations of the post-traumatic stress disorders in soldiers returning from World War 1. Prior to 1920, Freud believed that most neurotic symptoms were related to the repressed experiences of infantile sexuality. After this time, Freud gave primacy to the experience of trauma, a position that became a central tenet of subsequent psychoanalytical theorizing and speculation (Miliora, 1998; Mills, 2004; Muller, 2009; Naso, 2008; Oliner, 2000). The traumas of war and the constant imminent threat to survival must surely come closest to repeating the feeling of infant helplessness and its associated anxiety. The proximal trauma triggers the distal archaic infant anxieties, resulting in a traumatic neurosis. Freud understood the symptoms, including repeated nightmares and reliving of the war trauma as an attempt to master the trauma psychologically. Freud had identified the phenomenon of the "compulsion to repeat" (Freud, 1893b, p. 105) both in actual life and in the transference relationship with the analyst in his earliest cases (Freud, 1914g) and understood this as a form of remembering. In Remembering, Repeating and Working-Through, Freud (1914g) came to the conclusion that psychopathology (neuroses) is a "magnification of universal human phenomena" (Van Haute & Geyskens, 2007, p. 33). The helplessness and dependency that we all experience as infants are re-activated in subsequent experiences of threat, anxiety and loss.

Unlike subsequent theorists like Donald Winnicott and John Bowlby who argued that infantile trauma could be avoided or mitigated by "good enough mothering", Freud believed that the original infant trauma could not be avoided because the felt helplessness of the infant is helplessness in relation to its own instincts. Freud thus proposed that infantile traumas are universal and differ only in their intensity between individuals and that such traumas have an impact on all subsequent development. According to this model, the child "attaches" to its mother out of fear of this feeling of helplessness and the attendant fear that it will not survive without assistance from caring adults. Thus the desire for contact and attachment is born of fear and is thus a secondary instinct. This position was subsequently challenged by the attachment theorists (Bowlby, 1940, 1958).

In summary, the affect-trauma model proposed that the symptoms of hysterical patients had hidden psychological meaning related to major emotional traumata that the patient had repressed (Freud, 1893a, 1893b, 1893c, 1893d). The struggle for expression of this trauma resulted in the presenting symptoms, which constituted a symbolic expression of the "strangulated affect" related to the trauma. Freud believed that the processes of abreaction and catharsis related to this trauma would resolve the patient's symptoms and cure them of their hysteria.

The topographical and structural models

In The Unconscious, Freud (1915) revisited and reworked his ideas. He proposed 'psychical systems' that he named Conscious, PreConscious and Unconscious; he referred to these as the 'psychical topography.' He coined the term 'depth psychology' to

indicate that he had advanced the field beyond the 'psychology of consciousness' (p. 173). Freud subsequently renamed his depth psychology, metapsychology, in which all psychological phenomena were examined from three different perspectives: topographical, economic and dynamic. The topographical analysis identified the system in which the psychic action was occurring; the economic analysis assessed the quantity of psychic energy being expended and the dynamic analysis explored the conflict between the pressures from instinctual drives (wishes, strivings) and the ego defences that are deployed to prevent the release of the forbidden material from repression (Quinodoz, 2005).

According to Freud's structural model, which he introduced in 1923, our personality is an organized energy system of forces and counter forces whose task is to regulate and discharge aggressive and sexual energy in socially acceptable ways (Gramzow et al., 2004). This model re-focused attention on the importance of the social environment and the role of relationships with primary caregivers (Mayer, 2001). Freud proposed three structures, which he termed id, ego, and superego. At birth, we are all "id" – a series of sexual and aggressive impulses that seek gratification (Freud, 1923a). The id, the home of unconscious drives and impulses, operates according to a primary process that is very different from conscious thought, or secondary process thinking. It has no allegiance to rationality, chronology or order, and is fantasy-driven via visual imagery.

As the child develops, so does the ego, the reality tester, the rational part of the personality. Freud actually used the German word Ich to denote this 'structure' in his structural model. 'Ego' was the English translation of this word, but its meaning denotes 'I' – that part of the self that a person recognizes as 'me.' It is the role of the ego to regulate the primitive impulses of the id, the relentless and punishing superego and the demands of external reality. The ego protects itself from the Unconscious by developing repressing forces (defences mechanisms) that keep repressed material from breaking through to consciousness (Freud, 1937). Gradually the child learns to delay immediate gratification, to compromise, accept limits and cope with inevitable disappointments. Freud defined the ego in two ways; firstly, as the structure needing protection from the Unconscious; secondly, as the repressing force that keeps disturbing material at bay. Since the process of repression is itself unconscious, there must be an unconscious part of the ego.

With this understanding came a change in the understanding of the role of anxiety. In his early theorizing, anxiety was understood to be related to the fear of discharge of unacceptable sexual or aggressive drives. Subsequently, Freud (1926) understood anxiety to be, simultaneously, an affective signal for danger and the motivation for psychologically defending against the (perceived) danger. Freud believed at first that repression caused anxiety; he subsequently came to the view that it was anxiety that motivated repression (Freud, 1926). Freud proposed four basic danger situations – the loss of a significant other; the loss of love; the loss of body integrity; and the loss of affirmation by one's own conscience (moral anxiety). When an individual senses one of these danger-situations, motivation for defending against the anxiety is triggered.

Freud distinguished between traumatic (primary) anxiety, which he defined as a state of psychological helplessness in the face of overwhelmingly painful affect, such as fear of abandonment or attack, and signal (secondary) anxiety, which is a form of anticipatory anxiety that alerts us to the danger of re-experiencing the original traumatic state by repeating it in a weakened form such that measures to protect against re-traumatization can be taken. He also revised his view about what was repressed, concluding that it was not traumatic experiences or memories but conflicted impulses, wishes and desires with their attendant anxiety that motivate repression. Hence, Freud shifted his focus from external trauma to a focus on inner conflict as the core of psychoanalytic theory and psychoanalysis (Eagle, 2011). Contemporary psychoanalytic theory reversed this shift, re-focusing on external (mostly interpersonal) trauma as the locus of psychopathology.

According to Freud, the superego develops between the ages of four and six years. The superego is formed out of the internalized or introjected values of parents (or significant other caregivers) (Freud, 1923a) and society and becomes the person's conscience from which an ego ideal, the standard by which one measures oneself, is formed (Kilborne, 2004). Subsequently, psychoanalytic scholars tried to integrate the topographical and structural models, but a discussion of this is beyond the scope of this paper – see Sandler and Sandler (1983) for a detailed exposition. The schematic representation (Figure 1) below captures the essential elements of the integrated topographical and structural aspects of this psychoanalytic meta-theory.

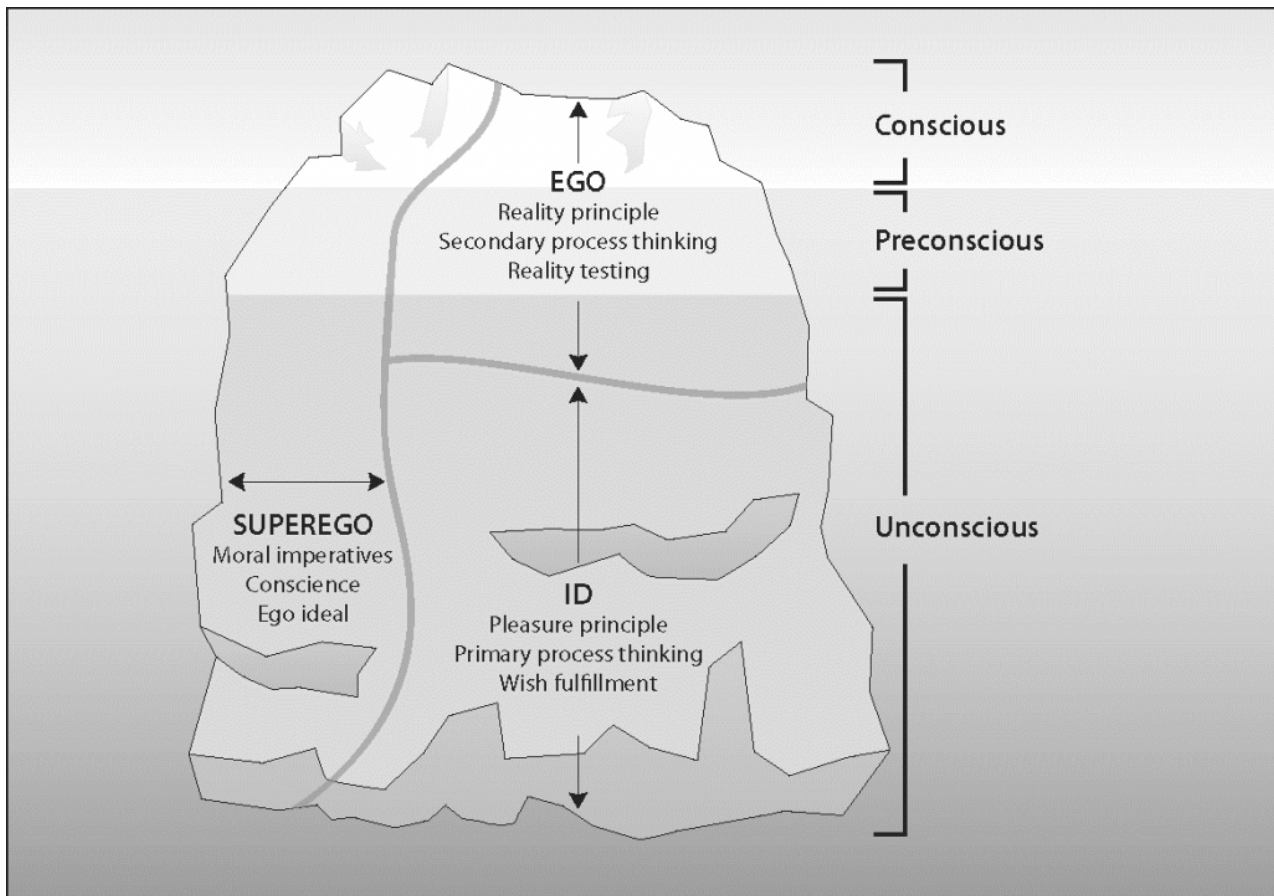**Figure 1: Freud's model of personality structure** (from Kenny, 2014)

Many of the ideas that were later to form the bedrock of psychoanalytic theory were present in these early writings; they were clearly evident in The Psychotherapy of Hysteria (Freud, 1893d) in which the concepts of the Unconscious, resistance, defence, transference and the notion of the analytic attitude were introduced. Freud's technique was not derived from theory. His technique was intuitive and evolutionary; theory followed to explain the observed clinical phenomena. We will now turn our attention to a brief overview of the essential elements of his technique, which I will later argue are the enduring aspects of Freud's contribution to current psychotherapeutic practice.

Psychoanalytic technique

Transference

If one were asked to identify the most profound clinical contribution of Freud's psychoanalysis, transference would be a worthy candidate. Freud himself viewed this discovery as pivotal to the psychoanalytic process. Freud (1905a) defined transference as

…new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis…they replace some earlier person by the person of the physician… psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment" (p. 116).

In this passage, Freud presages the concept of 'preverbal trauma' – a lynchpin in current psychoanalytic theorizing – which, while not available to episodic memory, has been stored affectively and is available to the analysis via the transference (Knoblauch, 1997; Slochower, 1996a).

… the part of the patient's emotional life which he can no longer recall to memory is re-experienced by him in his relation to the physician… (Freud, 1910, p. 51).

In the transference the analyst-patient relationship comes to resemble the mother-child relationship (Freud, 1912). Transference phenomena are unconscious and from the outset, serve both the functions of resistance and revelation. Transference is encouraged in the analytic situation through the adoption of an accepting and non-judgmental stance.

Free association

Free association was not Freud's invention. It has a long history in the arts beginning with its first recorded appearance in a comic play (The Clouds) by the ancient Greek playwright, Aristophanes, in which the subject was instructed (by the character playing Socrates) to lie on the couch and say whatever came into his mind (Rogers, 1953). Free association became the first "fundamental rule" of psychoanalysis (Freud, 1923a). In the second stage of technique development, Freud abandoned both hypnosis and abreaction, replacing them with a new focus on free association and the analysis of the resistance. The German freie Einfälle has the meaning "spontaneous thoughts" by which

Freud meant utterances that were not goal-directed or self-critical (Lothane, 2006). The analysand is instructed to allow a free flow of associations, emotions, and images to emerge. When a defensive blocking of those associations occurs within the analysand, this blocking is called repression. When it is motivated by the analyst-analysand dyad via the transference, it is called resistance. Freud hoped that the technique of free association would simultaneously expose and undo both repression and resistance (Boag, 2010). Free association required the patient to say whatever came into his mind, with no attempt to censure or organize his thoughts, thereby becoming a passive observer of his own stream of consciousness. Freud instructed his patients to "Act as though…you were a traveller sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views…you see outside" (Freud, 1913, p. 135).

Freud (1923b) was so impressed with free association that he thought the material arising from its outcomes warranted a new name – psycho-analysis. Freud found that the material produced from free association "hinted at hidden meaning" and that it was the analyst's task to discover these meanings. To do so, the analyst was required to "surrender himself to his own unconscious mental activity, in a state of evenly suspended attention… and by these means to catch the drift of the patient's unconscious with his own unconscious" (p. 239).

Interpretation

The technique of interpretation was developed to explain the influence of primary process, which is accessed via free association. It has many functions, including making connections between seemingly disparate utterances of the patient, confirming, clarifying, confronting patients with their contradictions, correcting misrepresentations, pointing out omissions or distortions, giving insight, synthesising, asking occasional, judicious questions and interpreting dreams. The type and complexity of the interpretation, ranging from "holding" (Slochower, 1996a, 1996b) to "symbolic decoding," depends on the level of pathology (Aguillaume, 2007, p. 239), the perceived readiness of the patient to hear the interpretation and the strength of his or her ego to manage it. Silence is also part of the process of interpretation. It is applied to increase the frustration of the patient to an optimal level. Too little frustration is too gratifying and is likely to prevent the patient from reaching repressed unconscious material; if it is too much, the analyst is perceived as persecutory (Arlow, 1961).

Freud believed that two conditions must be met before an interpretation is given – the patient's repressed material must be judged to be close to consciousness and he must be firmly attached to the analyst via the transference to prevent flight, either from the repressed material or from the analysis itself. Guntrip (1993) similarly observed that "[p]sychoanalytic interpretation is not therapeutic per se, but only as it expresses a personal relationship of genuine understanding" (p. 140), thus highlighting the importance of the therapeutic alliance (transference, attachment to the analyst) as the bedrock of the psychoanalytic process, without which psychoanalytic technique cannot be effective.

The aim of all psychoanalytic interpretation is to strengthen the ego via self-knowledge through the demonstration of the activity of the defences that prevent the gaining of "insight" (Sandler, Dare, & Holder, 1973). Interpretations may be directed at the resistances (Castelnuovo-Tedesco, 1986), content (Blomfield, 1982) or transference (Schafer, 1982; Stewart, 1987). In all forms of interpretation, the task of the analyst is to help the patient become aware of the repressed aspects of his mind (Freud, 1917). However, this may involve change and "[c]hange is seen quite routinely as involving loss of control and a danger of losing one's identity, separateness, and wholeness" (Castelnuovo-Tedesco, 1986, p. 262). Thus, the patient resists this process; s/he tries to avoid becoming conscious of his or her own wishes and impulses. Transference interpretations are directed to the unconscious, with the aim of making unconscious sources of pain conscious and thus available for scrutiny. Freud believed that the emotional aspects of insight and working through could only be developed and interpreted in the transference, in the immediacy of the here-and-now, which, during the course of the analysis "becomes a condensed, co-ordinated, and timeless version of past and present" (Schafer, 1982, p. 77).

The concept of counter-transference, defined as the effect of the patient on the analyst's unconscious feelings (Castelnuovo-Tedesco, 1986, p. 262), and considered such a centrally important part of the analytic relationship (Armony, 1975; Bernstein, 1993; Opdal, 2007) was infrequently mentioned in the writings of Freud. However, Freud was aware of its existence; his recommendation that all analysts undergo analysis and self-analysis implies that the analyst's self can intrude on the therapy in unhelpful ways (Freud, 1910k).

Resistance and defence

Freud was intrigued by the phenomenon of resistance – it appeared early and frequently in his writing. He emphasized that although psychoanalytic technique had undergone major revisions, the

…aim of these different techniques has, of course, remained the same. Descriptively speaking, it is to fill in gaps in memory; dynamically speaking, it is to overcome resistances due to repression (Freud, 1914g, p. 148)… [the analyst] employs the art of interpretation mainly for the purpose of recognizing the resistances which appear there, and making them conscious to the patient (p. 147).

Patients enter psychoanalysis with both hope and dread (Mitchell, 1993). The psychoanalytic situation is somewhat seductive in its invitation to say whatever is on one's mind to a receptive and non-judgmental other. Most analysands welcome the opportunity to unburden themselves, as a confessant with his/her priest, and experience the relief of confession (i.e., catharsis/abreaction). As the analysis proceeds, the patient's communications begin to include material that s/he may not understand or initially did not feel the need to discuss. Guilty secrets and aggressive and sexual fantasies emerge that arouse fears of retaliation and punishment, or loss of self-esteem and the esteem of others. The patient thus experiences ambivalence – the pull to continue with self-exploration and the push to retreat into previous modes of adjustment for which s/he had

developed coping strategies. The patient is now in a dilemma; s/he must choose between the known psychological discomforts of his current life or anxiously plunge into exploration of dangerous possibilities for change. The hesitation, doubts and fears that this situation creates is the essence of resistance (Castelnuovo-Tedesco, 1986; Menninger & Holtzman, 1973; Sterba, 1951). Resistance and defence manifest in many forms including concealment of known facts, forgetting, tardiness, absences, prolonged silences, intellectualization and rationalization, somatization, acting out, erotization, sublimation, projection and displacement (LeCroy, 2000).

Regression (transference neurosis)

Regression is a highly contested concept within psychoanalysis, as Bion's quip illustrates – "Winnicott says patients need to regress; Melanie Klein says they must not regress; I say they are regressed" (Bion, in Britton, 1998, p. 71). Psychoanalytic treatment involves the induction, via free association and the uncritical and unobtrusive presence of the analyst, in a setting of introspection and understanding, of a regression (also called the "transference neurosis"), in which the analysand becomes "childlike" (i.e., returns to more primitive ways of feeling, experiencing and behaving, including a preoccupation with the self) and emotionally dependent on the analyst, so that s/he can grow up again with a more benign parent/analyst, having recollected, understood and mastered repressed experiences.

Winnicott (1954) reconceptualized the analytic setting as a reparative mother/infant relationship, in which the therapist provides some of the maternal functions missing in the original mother/infant dyad and becomes a new object or secure base, in attachment theory terms. The experience of a maternal presence that is unobtrusive, reliable, and highly attuned to the patient's inner experience so that the patient may find a "transformational quasi-maternal object relation in the analytic experience" (White, 2006, p. 139), allows a re-working of the original object relation that is "…known not so much [as] an object representation, but as a recurrent experience of being – a more existential as opposed to representational knowing" (Bollas, 1979, p. 14). Because the analyst cannot fulfil the patient's anachronistic wishes, the patient becomes increasingly frustrated and angry with the analyst. The anger may be expressed directly or in the form of resentment, depression or discouragement. Although Freud believed that frustration, of itself, was not an effective form of treatment, he viewed frustration as the main source of action in effective psychoanalysis.

All of the patient's symptoms may be viewed as attempts to simultaneously suppress, repress or express anger (rage) and helplessness. All of the patient's unconscious strivings, impulses and neurotic patterns are expressed in the transference relationship and thus become evident to both analyst and patient and thereby available for examination and verbal communication. The constancy of the therapist through all the oscillations in the mood and behaviour of the patient is reassuring, stabilizes the patient and gradually frees him/her from transference distortions, which in turn reduces the extreme fluctuations in the patient's mood. All the while the unregressed, healthy part of the patient's ego (the observing self) forms an alliance with the therapist to assist in overcoming resistance to treatment, to become aware of the transference distortions and

to remain motivated in the task of self-exploration (introspection) (Bion, in Britton, 1998, p. 71).

Subsequently, Winnicott and Balint understood regression as the process whereby the patient connects with a deeply buried part of the mind – Winnicott's "true self," or Balint's "basic fault." Winnicott (1955) paid particular attention to making the analytic setting predictable, reliable and constant – "…the setting represents the mother… and the patient is an infant" (p. 20). The setting may be understood as an extension of the analyst's mind and as a container of early emotions (Sterba, 1951). Winnicott (1955) distinguished regression and reassurance, which he considered should rarely form part of psychoanalytic technique. "The patient comes into the analytic setting and goes out of it, and within that setting there is no more than interpretation, correct and penetrating and well-timed (p. 25)".

Winnicott (1955) and most who came after him, argued that in the transference, the past comes into the present of the analytic relationship; in regression, the present becomes the past. For other writers, regression signals the need for a change in psychoanalytic technique, such as a withdrawal from active intervention and interpretation "in order to give the patient's self-experience sufficient time and space to unfold" (Spurling, 2008, p. 527). Similar descriptions of this process appear in, for example, Ferenczi's "principle of relaxation," Winnicott's "regression to dependence," Balint's notion of life becoming "simpler and truer" (Balint, 1968, p. 135; Carpelan, 1981; Gilmore, 2005); Slochower's (1996a, 1996b) "holding" in which the "otherness" of the analyst is minimized in order to prevent impingement on the patient's unfolding process; or Bollas's (1996b) use of the analyst as a "transformational object" (p. 247) rather than a transference object that facilitates the patient's struggle to know his true self. The purpose of this process of regression is to provide the basis for the emergence of hope and a new beginning (Winnicott, 1955).

Termination

We will complete this brief overview of Freudian analytic technique with a few words about termination. Termination has always been a vexed issue (Ekstein, 1965; Klein, 1950), even today (Awad, 2006; Ferro, 2008) and although many areas of psychoanalytic theory, technique and practice are contested, issues related to termination remain among the most problematic. Freud's scepticism about the efficacy of psychoanalysis as a therapeutic or prophylactic agent grew over the course of his life. Towards the end of his life, Freud (1937) wondered whether there was ever "a natural end to an analysis…" (p. 219); he thought not, speculating that the strength of the instincts and the defences that arose in the struggle to contain them may make the analysis ineffective or the "duration interminable" (p. 220). He described psychoanalysis as the third impossible profession after education and government in "which one can be sure beforehand of achieving unsatisfying results" (p. 248). Nonetheless, Freud (1937) imagined that a satisfactory outcome of psychoanalysis would fulfil two requirements:

…first, that the patient shall no longer be suffering from his symptoms and shall have overcome his anxieties and his inhibitions; and secondly, that the analyst shall judge that

so much repressed material has been made conscious, so much that was unintelligible has been explained, and so much internal resistance conquered, that there is no need to fear a repetition of the pathological processes concerned (p. 219).

These goals are much less ambitious than the early hope of attaining a "…perfect Freudian man , the post-ambivalent genital character" (Ekstein, 1965, p. 58-59). In Analysis Terminable and Interminable, Freud (1937) concluded:

Our aim will not be to rub off every peculiarity of human character for the sake of a schematic 'normality', nor yet to demand that the person who has been 'thoroughly analysed' shall feel no passions and develop no internal conflicts. The business of the analysis is to secure the best possible psychological conditions for the functions of the ego (p. 250).

Beyond Freud's Psychoanalysis

Schisms arose early in the theory and practice of psychoanalysis and there was little love lost between Freud and his fallen acolytes. There were four main reasons for the schisms:
(i) Interpersonal processes and the role of nurture (i.e., the environment) came to the fore in contrast to the purportedly intrapsychic focus of the original theory;
(ii) There was disagreement about the primacy that Freud afforded to sexuality and a shift in emphasis from sexual to social (i.e., interpersonal) causes of psychopathology;
(iii) There were disagreements about technique and the locus of therapeutic action; and
(iv) There was a change in focus from pathological development to normal developmental processes.
Several new theories and therapeutic approaches emerged in rapid succession, which I briefly review here.
Object relations psychoanalysis

For Melanie Klein, the first proponent of object relations theory, the internal world of the infant comprises "primitive imagos" defined as the visceral, kinaesthetic, and emotional experiencing of internal, "phantasied" parental figures, in part, whole, or in combination (the parental couple) that constitute the earliest objects, and which appear from birth. These phantasies are the psychic representation of the instincts – "the affective interpretations of bodily sensations" (Isaacs, 1948, p. 88) that are necessarily preverbal and pre-visual, and that are experienced as either pleasurable (good e.g., satiation at the breast) or unpleasurable (bad e.g., hunger) (Klein, 1927, 1948, 1975). Phantasies are the stuff from which the ego defences of introjection and projection arise. For Klein, the child's inner world is built upon the introjection of a good and a bad (persecuting and attacking) breast and not on chronologically continuous memories or images of reality. The quality of these first objects is a product both of the infant's perception of its mother and of its projection of its own feelings into the mother. Thus, these internal objects do not necessarily represent "real" external objects because they have been transformed by the process of introjection (Riviere, 1952). Through the process of symbolization, the internal

world of phantasy becomes linked to the external world and eventually to reality testing (King & Steiner, 1991; Klein, 1950).

The infant moves from "symbolic equation" in which the object is omnipotently controlled to a position in which the object is relinquished, mourned and then symbolized. The new introjected internal objects become available to the ego and assist, through processes of identification and assimilation in the child's negotiation with external reality. Klein introduced two stages of psychic development i.e., the paranoid-schizoid and depressive positions, and two defences – splitting and projective identification that arise in response to psychic threats, which constitute "…a configuration of object relations, anxieties and defences that persist throughout life" (Segal, 1973, p. ix) that have had a significant influence on subsequent psychoanalytic theorizing. Although all four of these concepts took very deep root in subsequent psychoanalytic theorizing, the proposed developmental stages were later disconfirmed by infant research (Beebe & Jaffe, 2008; Beebe & Lachmann, 1988).

Klein's object relations theory, to be applauded for attempting to understand and articulate the contents of the mind of the preverbal infant, is essentially solipsistic. All the action occurs in the mind; the paranoid-schizoid position constitutes a world beset by projections and introjections in which there is no genuine contact with an external other, who is reduced to a container for projections; in the depressive position, the infant lives in a world of "phantasy" until the process of integration of the "good" and "bad" breasts begins and the healthy infant introjects the 'whole', 'real' mother. The notion of the encapsulated, solipsistic mind of the Kleinian infant cannot be sustained because the origin of the original contents of the mind cannot be explained. Further, Klein's ontological assumptions that emotions and thoughts constitute entities that can be expelled or introjected i.e., located in space misrepresents the embeddedness of the infant already being-in-the-world (Heidegger, 1926/1962) of interpersonal relationships. Enter the phenomenological psychologies…

Interpersonal, intersubjective and relational psychologies

The concept "relational" (for a detailed discussion, see Kenny, 2014) separated post-Freudian psychoanalytic thinking from classical drive theory and integrated two major theoretical traditions – the British object relations theories and American interpersonal psychoanalysis. The latter focused on current interactions between analyst and analysand, rather than intrapsychic structure, and the analyst's empathic-introspective stance while object relations theory emphasized the internal world of objects (which resulted in the neglect of actual relationships beyond the earliest primary relationships between mother/caregiver and infant).

Another key interest in post-Freudian theorizing was the role of the environment in shaping personality. Hartmann (1939) argued that humans were designed to survive physically and psychologically in their environments and that infants are born ready, with "conflict-free ego capacities" to interact with an "average expectable" environment. Harry Stack Sullivan (1953) also emphasized that personality unfolds in an interpersonal context, in the recurrent interactions between self and others, that human behaviour could

only be understood within an "organism-environment complex" and that the innate physiological and emotional needs of the infant could only be satisfied in an interpersonal context, in the first instance, by the mother. Thus, in therapy, Sullivan sought explanations for psychopathology in a detailed analysis of the interactions between the patient and his significant others, rather than in Freud's intrapsychic conflict or Klein's projective identifications.

One of Sullivan's most significant contributions was his understanding of the devastating effect that an attack via ridicule, mockery, misattunement or other invalidating response on the "tender emotions," that is, feelings of love and gratitude or the expression of highly valued thoughts or memories, has on development. Repeated failure of validating experiences of these tender emotions from caregivers results in a chronic sense of personal devaluation, dysphoria, emptiness and worthlessness. Future exposure or expression of these feelings risks the experience of shame, which is felt with devastation. For a detailed discussion, see Cortina and Marrone (2003).

The increasing importance assigned to the mutual influence of the analyst-analysand dyad as the locus of therapeutic action became known as the intersubjective field (Stolorow, Brandchaft, & Atwood, 1987). The importance of interactive mutual influence patterns in psychological development has been recognized by a number of key researchers, and it appears in many forms; for example, in Vygotsky's concept of the "inter-mental" (Atwood & Stolorow, 1984), in Fairbairn's "innate interpersonal relatedness" (Vygotsky, Hanfmann, & Vakar, 1962), Sullivan's (1953) "interpersonal field", and in the accounts of both self-psychologists (Fairbairn, 1946) and relational (Mitchell, 1993) and intersubjective/existential psychoanalysts (Stolorow, 2005), which in Freudian terms represents the transference-countertransference constellation. Both the new wave of psychoanalysts and existential phenomenologists (e.g., Heidegger, Sartre and Merleau-Ponty) argue that we are embedded (and only exist) within our social/relational context. There is no being; only a "being-in-the-world" (Kohut, 1971, 1977, 1984); there is no baby, only a "mother/baby couple" (Winnicott, 1960). I have argued elsewhere that this is a somewhat extreme view that is not supported by research in infant development and the mother-infant dyad that shows the interactive mutual influence between mothers and their infants as separate agentic beings-in-relationship (Kenny, 2013).

Ego psychology

Hartmann's work was foundational for a generation of developmental ego psychologists like René Spitz (1945, 1950a, 1950b, 1951) whose study of children who failed to thrive in foundling homes during and after the Second World War left no-one in doubt about the crucial role that the caregiving environment plays in both physical and emotional development. Spitz was responsible for critical new conceptualizations of the role of the mother in development, the reciprocal influence of the mother-infant dyad, and stranger anxiety, all concepts derived from observations, interviews and longitudinal follow up of mother-infant dyads. Other influential developmental ego psychologists were Margaret Mahler and Edith Jacobson. Jacobson (1964), in her book, The Self and the Object World, reworked Freud's concepts of inwardly directed sexual and aggressive drives to

include the importance of environmental influences, in particular early relationships, and the importance of interactions between biology and experience in shaping development.

Self-psychology

One of the most influential thinkers to emerge from ego psychology was Heinz Kohut (1913-1981). His work departs in significant ways from his predecessors in that he conceptualized human experience, not in terms of forbidden wishes, conflict and guilt, but in terms of self-experience, of isolation and alienation from oneself and others, that gave rise to a sense of meaninglessness and an absence of inner vitality or sense of joie de vivre. Kohut (1971, 1977, 1984) gave primacy to the empathic mode of observation, in which the analyst is an active participant who enters into the subjective world of the patient's experience. Kohut's self-psychology model is founded on three basic needs, or selfobject experiences , for the development of a healthy sense of self. These are the need to:

(i) be viewed with joy and approval, to have another who supports the child's sense of vigour, greatness and perfection;

(ii) have a powerful other from whom the child may derive a sense of calm and infallibility; and

(iii) have self objects who are like the child, with whom the child can identify and find a place in which s/he feels at home, like the others there.

Each of these developmental self object needs are reproduced in psychoanalysis in three transference relationships, termed the mirroring transference, the idealizing transference and the alter ego or twinship transference, respectively. There is empirical support for the existence and independence of the three types of self object needs proposed by Kohut as well as their association with attachment quality and affect regulation (Bacal, 1994).

Perhaps the greatest shift from classical psychoanalysis in self-psychology is the centrality assigned to the curative power of attunement and empathy, rather than insight or interpretation. Kohut (1984) believed that optimal empathic failures – those failures of empathy in the analyst that can be successfully managed by the patient – contribute to the development and consolidation of self-capacity, which entails the ability to tolerate the re-integration of previously rejected or split-off parts of the self. This process constitutes structural change in psychoanalysis, which is argued to have strong parallels in the development of psychic structure in the infant.

Attachment-informed psychotherapies

John Bowlby's (1969, 1973, 1980, 1988) attachment theory represents both a progression and a major break from contemporaneous psychoanalytic theory. Even though Winnicott (1960) believed that "Freud… neglected infancy as a state" (p. 587), psychoanalytic theory has always had a developmental perspective, founded on the principle that early experience, particularly within the mother-infant dyad, underlies the development of psychopathology, which is understood to be a manifestation, under conditions of stress, of problematic experiences with primary caregivers during infancy and early childhood.

There are…good reasons why a child sucking at his mother's breast has become the prototype of every relation of love. The finding of an object is in fact a re-finding of it

(Freud, 1905b, p. 222).

In his final theorizing, Freud (1940) afforded a central importance of the mother to the child's development, stating that the child's relationship with its mother was "…unique, without parallel, established unalterably for a whole lifetime as the first and strongest love-object and as the prototype of all later love-relations – for both sexes" (p. 65). Freud's view of the importance of the mother in development and by extension the importance of the therapist (as mother-like) in psychoanalysis still resonates strongly within current psychoanalytic theorizing and practice, particularly in attachment-informed psychotherapy.

Attachment theory rejected the libidinal, stage-based and fixation-regression models of psychopathology that proposed that behaviour was motivated by intrapsychic conflict and phantasies and that pathology represented a retreat to an earlier stage of development (Cortina & Marrone, 2003; Holmes, 2010; Slochower, 1996a, 1996b). It also challenged the psychoanalytic view of the mother as an object of drive gratification ["… love has its origin in attachment to the satisfied need for nourishment…" Freud (1940, p. 65)], which Bowlby (1969) famously described as the "cupboard-love theory of object relations" (p. 178). Psychoanalytic theory viewed infants as unresponsive to external stimuli at birth and imagined an undifferentiated or narcissistic infant ("…the auto-erotic instincts…are there from the very first" (Freud, 1914, p. 77).

While this view remained foundational in the theories of Melanie Klein (1948, 1975), Margaret Mahler (1967), Thomas Ogden (1989a, 1989b; 1990, 2002), and Frances Tustin (1969, 1986, 1990), such views have not been verified by infant observation and infant research and do not form part of the understanding of the nature of the relationship between mother and infant in attachment theory (de Litvan, 2007). The advent of precise methodologies for assessing the cognitive and perceptual skills of infants (Alfasi, 1984; Bell, Greene, & Wolfe, 2010; Bowlby, 1980, 1988) as well as their capacity for relationship have painted a picture of a much more capable, relational infant than the classically drawn psychoanalytic infant (Bretherton, 1994; Kenny, 2013), one who is neurologically equipped to co-construct and make sense of his or her experiences and relationships and to engage in meaningful social interaction with his or her caregivers from birth (Beebe, 2000; Beebe, 2006; Beebe & Jaffe, 2008; Beebe et al., 2010; Feldman, Greenbaum, & Yirmiya, 1999).

Fragmentation of psychoanalytic theory

In addition to the major developments offered in the theories discussed in the previous section, the post-Freudian psychoanalytic landscape became strewn with new theories. Rangell (2006) deplored this proliferation and the consequent fragmentation of theorizing in the field. He argued that many post Freudian theories suffered from either one of two fallacies, the first of which was pars pro toto (substituting a part of the theory and treating it as a whole). He includes in this group Carl Jung (focus on mysticism and spirituality),

Alfred Adler (focus on aggression and power), and Otto Rank (focus on infancy and the birth process). Freud described his erstwhile protégés' (Jung and Adler) contributions to psychoanalysis as "twisted re-interpretations" of his own theories (Freud, 1918, p. 7). On Jung's position with regard to archetypes, Freud had this to say:

I fully agree with Jung in recognizing the existence of this phylogenetic heritage; but I regard it as a methodological error to seize on a phylogenetic explanation before the ontogenetic possibilities have been exhausted. I cannot see any reason for obstinately disputing the importance of infantile prehistory while at the same time freely acknowledging the importance of ancestral prehistory (Freud, 1917, p. 7).

The second fallacy involves setting up false dichotomies and polarizing camps along those lines. Rangell cites the very public dispute between Otto Fenichel and Franz Alexander with respect to the proper analytic attitude. Fenichel advocated adherence to the neutral analytic stance requiring the analyst to give insights via interpretations while Alexander asserted that the curative factor in therapy was the corrective emotional experience, in which the analyst provided what had been missing in the analysand's early life. A careful reading of Freud's case studies shows that such a division is a false dichotomy; the analytic attitude was intended from the outset to be both insight-producing and emotionally corrective.

The field abounds with "straw man" fallacies. Stolorow (1992, 2006) argued that attempts to dichotomize human experience as subjective (internal) or objective (external), or intrapsychic or interpersonal are misguided and constrain genuine understanding of experience. For example, the initial danger situation that signals anxiety – helplessness in the face of overwhelming affect – is an internal experience. When the infant learns that an external object, such as a parent or other caregiver can alleviate his distress, the danger situation becomes one of fear of the loss of the love object or fear of the loss of love from the love object, which are interpersonal experiences. When the love object is internalized, that is, a mental representation of the caregiver is constructed 'in mind' as primarily nurturing or punishing, available or unavailable, predictable or unpredictable, the experience once again becomes internal. Mitchell (1993), a relational psychoanalyst, likewise agrees that all personal motives have a long relational history.

The very capacity to have experiences necessarily develops in and requires an interpersonal matrix…there is no experience that is not interpersonally mediated. The meanings generated by the self are all interactive products (p.125)…If the self is always embedded in relational contexts, either actual or internal, then all important motives have appeared and taken on life and form in the presence and through the reactions of significant others (p. 134).

Dissolution of psychoanalytic theory: the descent into folly

Arguably worse than straw man fallacies in psychoanalytic theorizing is the wild and uncontained proliferation of theories based solely on the use of metaphor and imagination. I refer here to the work of Frances Tustin (1969, 1986, 1990), Jeanne Magagna (2016), Judith Mitrani (2008, 2011), Thomas Ogden (1989a, 1989b; 1990, 2002,

2007), Anne Alvarez (1992), Dana Amir (2013), and Michael Eigen (2014) to name but a few. Lest I be labelled resistant or hostile for expressing the views below, I preface my comments with a statement about the judicial use of metaphor in psychotherapy, eloquently elaborated by Jeremy Holmes (2010).

…[there are] formal similarities between poetry and psychoanalysis…both regularly arouse suspicion and incomprehension, yet people often turn to them in states of heightened emotion… since the appropriate image or metaphor can mirror or evoke feelings in the listener in a way that facilitates empathic attunement…metaphors are an indispensable means by which we reach into another's inner world (p. 87).

Notwithstanding, metaphor is not science. Although there are different modes of observation – empirical, introspective, philosophical – the continued reliance on metaphorical concepts in psychoanalytic theory and practice that are not grounded in rigorous observation, specifically empirical research, are problematized because the discipline now has a firm basis upon which to theorize infant development, inner states of mind, and psychic functioning. Perusal of recent psychoanalytic writing reveals an a(nti)-scientific stance. Indeed, the offerings of some contemporary psychoanalysts are fanciful, at times confused, self-contradictory, and frankly, incomprehensible. I present below some examples from these writers of what I call "metaphor gone mad." The work of scholarship is not the reader's job. It is best to present the case, using reason and evidence or omit the point.

Frances Tustin, who ignored 40 years of co-extensive scientific research into infant development and autism spectrum disorders, spawned a generation of adherents of her theories on infant development and childhood autism and "autistic states" which, she claimed, occurred in all of us (Kenny, in press). Tustin (1991) defined autistic states as "endogenous auto-sensuality…sensation-dominated reactions…that swathe children in a sensual protective shell" (p. 588) which Esther Bick calls "a second skin" (Bick, 1968). Autistic states, according to Tustin, are a form of "auto-generated protection" comprising "autistic sensation objects which make the child feel strong and safe, and autistic sensation shapes (i.e., endogenous swirls of sensation) which are calming and tranquillizing" (p. 588).

What are these? What is wrong with them – please provide a one paragraph outline. You cannot assume your reader is familiar. Tustin's many acolytes embraced these concepts and her unverifiable conception of infants uncritically. For example, Thomson-Salo (2014) advises that "…observers need to develop a sensitivity for possible unconscious processes… and subtle projections…" in infants (p. 11). Magagna (2016) alerts us to "…the baby's fears of dissolution…" (p. 30) and asserts a baby's rashes are the "…the container…for baby's intolerable anxieties…" (p. 33). When baby moves and cries loudly, "…he is attempting to hold himself together… to prevent terror of a dead end… of spilling out… Mother's touch derives its power from its significance as an adhesion…" (p. 36). In like manner, Dubinsky (2010) interpreted the rhythmic finger movements of a six-week-old infant as "…an urge to identify with the flow of milk by projective identification…" (p.

6). Autistic behaviours purportedly protect the child from "sensing the unthinkable dread" and the "unbearable awareness of bodily separateness" (Mitrani & Mitrani, 2015, p. xxx).

Each of these statements assume a level of cognitive development in the infant that could not have occurred – indeed, many adults never reach the required level of abstract thought to grasp these assertions about the meaning of one's behaviour. For example, to have a fear of dissolution implies that infants have implicit or acquired ontological concepts of existence and non-existence; to prevent the terror of arriving at a dead end, infants would need concepts of space and the ability to locate themselves in space and time, as well as the capacity to think metaphorically (a "dead end" is both a physical possibility and a complex metaphor). What does it mean to "identify with the flow of milk by projective identification?" Identify in what way and with what precisely? Such comments rely too heavily on speculative claims and indeed lack meaning. Why is awareness of bodily separateness unbearable? The development of body awareness begins at birth, is part of normal development and is an exciting process for infants (Sokol, Müller, Carpendale, Young, & Iarocci, 2010). Mother's touch does not derive its significance "as an adhesion" but as a means of bonding with and soothing her infant. Mother's touch assists with stress modulation and emotional reactivity reduction. Attuned touching is an important precursor to the development of self-regulation (Jahromi, Putnam, & Stifter, 2004). Depressed mothers show heightened interactive discordance with their infants with respect to gaze and touch, which represent early forms of intrapersonal and dyadic discordance that may have lifelong adverse effects (Beebe et al., 2012). These are much more helpful and meaningful ways of talking about the significance of mother's touch to her infant than resorting to nebulous concepts such as "adhesion" and "adhesive identification" which have no psychobiological referent.

Many catastrophic interpretations of infant behaviour (e.g., primitive dread, terror, fear of falling, disintegrating, dissolving, spilling out etc.) have been co-constructed retrospectively in clinical, psychoanalytic settings with adult patients, many of whom are struggling with early relational trauma. The narratives that emerge from this process may be helpful to the adult patient, but they have little to offer a nuanced understanding of normal infant development. The translational process – moving from narratives derived from adult psychoanalysis to theorizing normally developing infants – has given rise to conceptual fallacies regarding infant development, such as the "adultomorphization" of infants (i.e., the process of ascribing capacities to infants that developmental neuroscience has demonstrated do not exist at the age/stage of development asserted by Tustian theories); and the pathologization of early states of normal infant development (Seligman, 2009; Seso-Simic, Sedmak, Hof, & Simic, 2010; Stern, 1994).

Why do apparently intelligent, highly educated clinicians adopt and endorse empirically unsubstantiated theories? I have long suspected a type of "groupthink" (Janis, 1972) among psychoanalysts that supports and amplifies illogical thinking. One recent example illustrates the point: Jeanne Magagna (2016) describes her experience in an infant observation group seminar supervised by Esther Bick.

We are afraid to speak our thoughts, afraid to disagree with the thoughts of Mrs Bick. It is not only respect for Mrs Bick's understanding that causes this passivity. It is also that we have settled for peaceful conformity with her thoughts for we are afraid that if we are different if we have separate identities, we might end up being the unwanted baby. (p. 35)

It is not surprising, then, that in these circles, there remains an uncritical acceptance of the notion that even normally developing infants pass through autistic, symbiotic, autistic-contiguous, undifferentiated, fused or merged states before developing a differentiated sense of self and other (Kenny, 2013). Symington (2008) similarly asserts that infants are born in an unintegrated state as "…a messy array of bits" (p. xix). Ogden (1989)has built the edifice of his psychoanalytic theory on the assumption that there must be an autistic-contiguous stage of development, which he describes thus: "[A]nxiety in [the autistic-contiguous phase] consists of an unspeakable terror of the dissolution of boundedness resulting in feelings of leaking, falling or dissolving into endless, shapeless space" (p. 127). There is no evidence to support this claim and indeed evidence to the contrary (Beebe, Jaffe, & Lachmann, 2005; Beebe et al., 2010; Beebe, Knoblauch, et al., 2005; Beebe & Lachmann, 1988; Beebe & Lachmann, 1994) that the autistic-contiguous phase precedes the equally empirically unsupported paranoid-schizoid and depressive positions of Melanie Klein.

The concept of "adhesive identification" has been enthusiastically adopted by those analysts who find themselves working with "primitive mental states" in patients who have failed to grow a "psychic skin" (Tustin, 1990), a state in which the afflicted individual has no concept of "…an internal space, no sense of separate identity… Out of catastrophic anxieties of unintegration, the patient adheres to the analyst, through adhesive identification, for example, by taking over some of the analyst's external characteristics…"(Bergstein, 2009, p. 616). Symington (2002) described this phenomenon as "glue-like attachment" between analyst and patient that "goes to make up the inner pattern of madness" (p. 121). I wonder whether this "inner pattern" has external representations? Symington does not enlighten us.

What are these authors talking about? Are they talking about the same phenomena? How can we know? Dare we speak our thoughts about these analysts' experiences and their interpretations of these experiences? Or do we remain passive and unquestioning while the theorizing becomes more and more incomprehensible and indeed, bizarre? There is now an abundant literature on the psychological effects of early trauma and the types of relationship impairments that accrue to early relational traumata. When we speak of insecure attachment (Pauli-Pott & Mertesacker, 2009), in particular, avoidant (Fraley & Marks, 2011) and disorganized attachment (Diamond, 2004), there is a shared understanding based on rigorous observational studies and other empirical research about the relational phenomena of interest. This in turn informs the therapeutic approach, including the nature of the attachment (i.e., transference) that the patient forms with the analyst (Muller, 2009; Schafer, 1982; Stewart, 1987) as part of the therapeutic dialogue.

Amir ([2013](#)), in a paper titled, The psychic organ point of autistic syntax, describes his aims in similarly surreal terms. Again, metaphor takes precedence over logic, coherence, meaning and empirical evidence.

This paper deals with autistic syntax and its expressions both in the fully fledged autistic structure and in the autistic zones of other personality structures. The musical notion of the organ point serves as a point of departure in an attempt to describe how autistic syntax transforms what was meant to constitute the substrate for linguistic polyphony into a one-dimensional, repetitive score, devoid of emotional volume. Autistic syntax denies the recognition of the human characteristics of both self and other, turning the other into an autistic object, which blocks, with his or her concrete presence, the hole created by his or her own absence as a psychological subject (p. 3).

What are autistic syntax and autistic structure? How can syntax be a transitive verb? What is the substrate for linguistic polyphony? What is the metaphor of the "organ point" meant to communicate in psychoanalytic terms?

Michael Eigen's work similarly enters the realm of dada and crosses into the surreal. In his book, Faith ([Eigen, 2014](#)), chapter seven is titled "Variants of mystical participation." In the opening paragraph, Eigen tells us that he does not know what he means by this phrase, perhaps it "loosely refer[s] to something sensed…[that] may occur in varied affective keys: dread, awe, love, heaven, hell, joy, ecstasy, horror, hope, hate" (p. 77). Mystical participation, he says, may be destructive or creative. By way of example, he reported that an episode of intense pain made him feel "invaginated" (i.e., turned inside out; "vaginal") – the aftermath of which was a "sense of Faith." He also tells us that he was once mesmerised by a hyena with whom he held eye contact for hours; at another time he was "meshed" i.e., "interpenetrated" (p. 79) with a young woman who had a "crush" on him; at yet another time, he described an "umbilical sensation" with a disturbed young patient after which he felt "free-floating radiance" (p. 82) and his patient reported "a radiant inner I-light" (p. 81), thereafter experiencing a miraculous cure from alcoholism and despair. Would that he could teach the secrets of mystical participation to us all so that we too can experience such ecstatic subjective states and such outstanding successes with our patients!

In a highly critical paper on the current state of psychoanalysis in the UK and USA (and indeed Australia), Kirsner ([2004](#)) references Kernberg's ([1986](#)) various characterizations of psychoanalytic institutes as monasteries, trade schools, art academies and universities. Kirsner identifies a religious, cult-like fervour in psychoanalytic circles and describes what he calls

…an odd religious element that suffuses psychoanalysis, even at scientific meetings, which so often has a sense of a religious observance as ritualistic…There is often an element of prayer, even incantation, at presentations… (p. 341).
Are paradigm plurality and theoretical synthesis possible?

Although arguably inevitable in the era of postmodernism and paradigm plurality, failure to achieve consensus with respect to basic concepts compromises not only the scientific status of a discipline, but also, in the case of psychoanalysis, its therapeutic practices. Rangell (2006) summed up the concerns of many in the field of psychoanalysis today: "Do we have many theories, hundreds of psychoanalyses or even in the opinion of some, guided by the democratic ideal, a theory for every analyst or even for every patient?" (p. 218). There have been many attempts to integrate and clarify psychoanalytic concepts into a coherent theory (Kenny, 2014). Otto Kernberg (Kernberg, 1969, 1974, 1976, 1995, 2001; Kernberg, Yeomans, Clarkin, & Levy, 2008) proposed a synthesis of instinct theory and the structural model with object relations models and ego psychology. Westen (2002) also attempted a synthesis of basic psychoanalytic concepts and the language used to described them. He wanted to clarify "…the implicit rules that guide psychoanalytic thought and discourse… avoiding [issues] that lead to theoretical imprecision and confusion of theory and metaphor" (p. 857). Frosh (2002) has likewise offered a set of generic definitions of the key concepts in psychoanalysis in an attempt to bring clarity to an increasingly diverse and complex theory. One of the most helpful attempts at synthesis was offered by Pine (1988), who argued that psychoanalysis has produced four "psychologies" – the psychology of drive, ego, object relations and the self.

(i) The psychology of drive is concerned with instinctual urges, wishes, fantasies, defence and conflict.

(ii) The psychology of ego is concerned with adaptation, reality testing, and "ego defects" (Hartmann, 1939), defined as developmental failures in adaptation that have resulted in diminished capacities for affect regulation, impulse control, or the attainment of object constancy.

(iii) The psychology of object relations (Fairbairn, 1944, 1946) is concerned with the internal images and dramas of the early object relations that are embodied in conscious and unconscious memories, which are repeated or acted out in current relationships and within the transference. Fairbairn proposed that children who had not experienced good enough mothering in early life increasingly retreated into an inner world of fantasy objects, which were used as substitutes for absent real objects, in order to satisfy the need for nurturing relationships.

(iv) The psychology of the self is focused on the ongoing subjective experience of the self (Kohut, 1977) and issues related to boundaries, feelings of fragmentation, continuity and self-esteem, and capacity to manage frightening self-states.

All four psychologies of psychoanalysis bring about change through interpretation (i.e., meaning-making) that resonates with the patient as "real" or "true", occurs within the immediacy of a mutually meaningful analytic relationship including transference and countertransference and the "experience-near" contact between patients and a phenomenologically present therapist, and which manages areas of ego defect or deficiency by holding, reconstruction, affective discharge, and explanation/interpretation that allows the patient to understand, verbalize (i.e., "mentalize") and gain some mastery over the areas of deficit. The question remains: is there an integrative glue that binds these four psychologies? One could argue, with Emde (1990), that the common denominator is the empathic availability of the therapist. Even in drive theory, the

therapist is non-judgmentally and calmly available to hear the shameful confessions of their patients with respect to their taboo sexual and aggressive impulses. Reliable availability, that engenders the therapeutic alliance and positive transference, is a pre-requisite for the experience of empathy. Empathy is creative, generative, affirmative and transactional. It is properly exercised from a "prepared mind," involves "vicarious introspection" and depends on "cognition, perspective-taking and a knowledge about the [patient] and the situation" (Emde, 1990, p. 887). Empathy shares the analytic space with interpretations, whose function is to guide the patient to his or her next step; good interpretations arise out of therapeutic availability and are expressed creatively through metaphor, paradox and even irony (Segal, 1980).

Since Alexander and French (1946) ("corrective emotional experience") and Kohut (1971, 1977) ("corrective empathic experience") – made therapist empathy the linchpin of successful therapy, and infant research has confirmed the importance of maternal attunement for healthy development, empathic attunement has become a key concept in many psychoanalytically orientated therapies. Analytic empathy and emotional availability are now understood to have a developmentally enabling role in adult psychoanalysis (Beebe & Lachmann, 2002). More recently, analysts talk of the "corrective relational experience" in interpersonal psychoanalysis (Fiscalini, 1994; Piers, 1998; Rotenberg, 2006), in which the "… actuality or "reality" of the analyst's personality plays a crucial role in the patient's clinical expression of his or her transference, and the patterning of its subsequent analytic life, thus forming an integral part of analytic data and process" (Fiscalini, 1994, p. 125).

Psychoanalysis need not be defined by a particular metapsychology, personality theory, developmental model or clinical theory. Stolorow, Brandchaft, & Atwood (1987) defined the aim of psychoanalysis as "the unfolding, illumination, and transformation of the patient's subjective world (p. 10)." Stolorow (1992) requires the concepts of psychoanalytic theory to meet two criteria in order to be relevant to therapeutic work: firstly, they must be "experience-near…that is, [they] pertain to the organization of personal experience" (p. 160); secondly, they must [occur] within a relationship, that is, they must be relational (Mitchell, 1988). Although the language of "experience-nearness" is relatively recent, the concept and its therapeutic focus have certainly been present in psychoanalytic thinking from its early days. See, for example, Freud's references to the importance of direct affective knowing:

To have heard something and to have experienced something are in their psychological nature two quite different things, even though the content of both is the same (Freud, 1915c, p. 176).

Instead of searching for seemingly illusory connections between the theories and practices of psychoanalysis, Fonagy (2003) advocates a radical decoupling of analytic theory from analytic technique in order to allow clinical practice to develop empirically and theory to evolve out of newer patterns of clinical practice. "The evidence that exists is for a theory of mind that contains unconscious dynamic elements. Evidence is, however,

lacking for the translation rules for moving from psychological theory to clinical practice" (p. 24). Concerns about privileging theory over practice have echoed through the decades from Freud to Fonagy – for example, from Guntrip (1975) : "Theory…is a useful servant but a bad master…Therapeutic practice is the real heart of the matter" (p. 145) and Wallerstein (2006) who sees the task as "…reconcil[ing] the search for meanings and reasons through the individual exploration of a unique human life with the effort also to fit the findings derived from that search into the explanatory constructs of a general theory of the mind…" (p. 307). Recently, Appelbaum (2011) offered the following radical reformulation of psychoanalysis as "a clinically based interpretive discipline" (p. 1) in which the core of psychoanalytic practice is unashamedly humanistic and where practice is "guided by the individuality of the dyadic encounter" (p. 1).

Psychoanalytic clinical practice was founded on trial-and-error; basic techniques like free association were derived empirically rather than deduced from pre-existing theory. Consequently, Kleinian analysts have learnt to be more circumspect in interpreting envy and destructiveness; Winnicottian analysts are more cautious about encouraging regression; and modern analysts are more focused on understanding mental states than forbidden drives and impulses. In this sense, current technique appears to remain more recognizably Freudian than the kaleidoscope of contemporary theories (Fonagy, 2003).

Conclusion

In this paper, I have traced the evolution of Freud's psychoanalytic theory and technique in the psychoanalytic scholarship of the past 115 years. Many of the early theories and techniques of psychoanalytic psychotherapy were identified, with modifications, in the early offshoots of "classical" psychoanalysis; in particular, object relations theory and attachment-informed psychotherapy, and in later developments in self-psychology, phenomenological/ existential/interpersonal, intersubjective, and relational psychotherapies. I have also identified problematic trends in contemporary theory and practice that eschew science or any form of empirical observation in favour of personalized accounts of the therapeutic process that privilege the use of intuition, metaphor idiosyncratic language, and the invention of psychic processes and theories that do not appear to have any basis in the psychobiology of human functioning.

It is my view that it is time the psychoanalytic community took stock of the current state of its practice to reverse this detrimental descent into theoretical and therapeutic disarray. Undisciplined theorizing and the creation of unsubstantiated concepts and neologisms have not advanced the cause; indeed, they obfuscate the value of psychoanalysis while confirming the views of the general public that it is an obscure and anachronistic art with no foundation in reality.

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