Fine-Tuning Problems in Relational Psychoanalysis: New Directions in Theory and Praxis

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Introduction

Relational psychoanalysis and the relational psychotherapy movement have become an international phenomenon. In just over a decade, the International Association for Relational Psychoanalysis and Psychotherapy (IARPP) went from being a New York based organization to an established international presence with forums and chapters in the United States, Australia, Canada, the United Kingdom, Israel, Mexico, New Zealand, Greece, Spain, Portugal, and Chile. In looking at its success, it becomes easy to appreciate the force, value, and loci of the relational turn:

(1) Relational thinking has opened a permissible space for comparative psychoanalysis and psychotherapy by challenging fortified traditions ossified in dogma, such as orthodox conceptions of the classical frame, neutrality, abstinence, resistance, transference, and the admonition against analyst self-disclosure.

(2) Relational perspectives have had a profound impact on the way we have come to conceptualize the therapeutic encounter, and specifically the role of the analyst or therapist in technique and practice. The relational turn has forged a clearing for honest discourse on what we actually do, think, and feel in our therapeutic work, thus breaking the silence and secrecy of what actually transpires in the consulting room. Relational approaches advocate for a more natural, humane, and genuine manner of how the therapist engages the patient rather than cultivating a distant intellectual attitude or clinical methodology whereby the analyst is sometimes reputed to appear as a cold, staid, antiseptic, or emotionless machine. Relational analysts are more revelatory, interactive, and inclined to disclose accounts of their own experience in professional space (e.g., in session, publications, and conference presentations); enlist and solicit perceptions from the patient about their own subjective comportment; and generally acknowledge how a patient's responsiveness and demeanor is triggered by the purported attitudes, sensibility, and behavior of the therapist. The direct and candid reflections on countertransference reactions, therapeutic impasse, the role of affect, intimacy, and the patient's experience of

the analyst are revolutionary ideas that have redirected the compass of therapeutic progress away from the uniform goals of interpretation and insight to a proper holistic focus on psychoanalysis as process.

(3) The relational turn has displaced traditional epistemological views of the therapist's authority and unadulterated access to knowledge, as well as the objectivist principles they rest upon. By closely examining the dialogic interactions and meaning constructions that emerge within the consulting room, relational psychoanalysis has largely embraced the hermeneutic postmodern tradition of questioning the validity of absolute truth claims to knowledge, objective certainty, and positivist science. Meaning, insight, and conventions of interpretation are largely seen as materializing from within the unique contexts and contingencies of interpersonal participation in social events, dialogical discourse, dialectical interaction, mutual negotiation, dyadic creativity, and reciprocally generated co-constructions anchored in an intersubjective process. This redirective shift from uncritically accepting metaphysical realism and independent, objective truth claims to reclaiming the centrality of subjectivity within the parameters of relational exchange has allowed for a reconceptualization of psychoanalytic doctrine and the therapeutic encounter.

No small feat indeed. But with so many relational publications that largely dominate the contemporary psychoanalytic scene, we have yet to see relational paradigms undergo a proper conceptual critique from within its own frame of reference. With the exception of Jay Greenberg (2001), who had turned a critical eye toward some of the technical practices conducted within the relational community today, most of the criticism comes from those outside the relational movement (see Eagle, 2003; Eagle, Wolitzky, & Wakefield, 2001; Frank, 1998a, 1998b; Josephs, 2001; Lothane, 2003; Masling, 2003; Richards, 1999a,b; Silverman, 2000). To my knowledge I have provided the most comprehensive critique of the relational movement to date (see, Mills, 2005a, b; Mills, 2012), and here I wish to further expound upon where I believe the relational school could improve upon its conceptual and technical practices.

Displacement of Drive Theory

From his early work onward, Stephen Mitchell (1988) stated that the relational model is "an alternative perspective which considers relations with others, *not drives*, as the basic stuff of mental life" (p. 2, emphasis added), thus declaring the cardinal premise of all relational theorists. He clearly wanted to advocate for a "purely" relational model that is opposed to drive theory when he declares that "the concept of drive, as Freud intended it, has been omitted" (p. 60) from the relational perspective. Greenberg (1991) makes this point more forcefully: The relational model is "based on *the radical rejection of drive* in favor of a view that *all motivation* unfolds from our personal experience of exchanges with others" (p. vii, emphasis added). Echoing Mitchell, Greenberg (1991) makes a universal proclamation attributed to all relational theorists when he states: "Analysts operating within the relational model of the mind are united in their claim that it is misguided to begin theorizing with drive" (p. 69). This attitude holds steadfast today to the degree that it has become the relational movement's motto emblazoned on the IARPP website:

Relational Psychoanalysis is the term that has evolved in recent years to describe an approach to clinical work that attracts many practitioners in different parts of the world. Although not a hard and fast set of concepts and practices, one core feature is the notion that psychic structure – at the very least, those aspects of psychic structure that are accessible to psychotherapeutic intervention – derive from the individual's relations with other people. This, of course, is intended as *an alternative to the classical view that innately organized drives and their developmental vicissitudes are, at root, the basis of psychic structure* (emphasis added).[1]

Notice the theoretical presupposition that "psychic structure . . . *derive(s)* [sic] from the individual's relations with other people" (emphasis added). So according to the flagship organization, psychic structure does not derive from the drives (*Triebe*), what is commonly translated into English as instincts, but rather derives from other people.

As I have elaborated with precision elsewhere (2010), this tenet is unfathomable and ultimately indefensible because you cannot have relationships without a body. We are embodied beings who cannot deny our evolutionary and material facticity. In fact, our embodied psychic processes such as drives, urges, pulsions, innate desires, organic impulses, yearnings, compulsions, evolutionary pressures, internal regulatory catalysts, motivations, and the like need a corporeal foundation lest we return to a protoscientific model of a caricatured Cartesian *cogito* floating out in space divorced of a physical medium. Moreover, our biological (bodily) and enmattered psychic (mental) activities that constitute "the basis of psychic structure" are a necessary condition for consciousness, object seeking (what Freud [1915] argued was the aim of a drive), and the higher order organizations of mind and relatedness to arise, without which we would not relate to anything. This single-minded antithesis of relationality versus drive theory is not only an unnecessary and unfortunate false dichotomy, but it is furthermore a philosophical embarrassment that the relational community could easily remedy by modifying its theoretical position.

It is not necessary to negate our biological drives or their psychophysiological-neurocognitive correlates in order to appreciate how relationships with others become internalized within psychic structure. This *either-or* theoretical bifurcation only highlights the political agenda behind the need for reform and revolution. But with the radical rejection of our embodied natures comes further *aporias* when relational theory wants to include the biological-developmental interactions that take place within the mother-infant dyad. And with the revival of attachment theory that has been annexed within relational circles (Beebe & Lachmann, 2014; Mills, 2005b), a biopsychosocial model of relationality is merely a logical corrective. One does not have to defend a flawed conceptual binary or refute the role of drives in order to *emphasize* the primacy of attachment and relatedness to other people. Both are coexistent and coextensive motivations underlying psychic structure: it simply becomes a matter of degree and the level of importance one wishes to highlight in constructing a theory of mind and human nature.

The centrality of interactions with others, forming relationships, interpersonally mediated experience, human attachment, the impact of others on psychic development, reciprocal dyadic communication, contextually based social influence, and the recognition of competing subjectivities seem to be universal theoretical postulates underscoring the relational viewpoint. These are very reasonable and sound assertions, and we would be hard-pressed to find anyone prepared to discredit these elemental facts. The main issue here is that these propositions are nothing new: Relational theory is merely stating the obvious. These are simple reflections on the inherent needs, strivings, developmental trajectories, and behavioral tendencies propelling human motivation, a point that Freud made explicit throughout his theoretical corpus, which became further emphasized by early object relations theorists through to contemporary self psychologists. Every aspect of conscious life is predicated on human relatedness by the simple fact that we are thrown into a social ontology as evinced by our participation in family interaction, communal living, social custom, ethnic affiliation, local and state politics, national governance, and common linguistic practices that by definition cannot be refuted nor annulled by virtue of our embodied and cultural facticity, a thesis thoroughly advanced by Heidegger (1927) yet originally dating back to antiquity. But what is unique to the relational turn is a philosophy based on antithesis and refutation: namely, the abnegation of the drives. As the relational tradition moves forward, I hope it will attend to and rectify these theoretical fallacies.

What about the Unconscious?

Another difficulty in determining the philosophical merit of relational theory is its perspective on the force and ubiquity of the unconscious. If relationality rejects the drives, does it not open itself up to accusations that it ignores, or even refutes, unconscious dynamic processes? Perhaps contemporary relationalists would concede that unconscious processes do exist, if they are not cast into the abyss of dissociation, and they would acknowledge the internalized nature of other people over drive derivatives, which I would support, such as the way introjects, part objects, self and object representations, and environmental encounters are incorporated and arranged within internal experience based on the unique configurations of self-organization that transpire in relation to others and one's being in the world. But this does not necessitate the abnegation of drive, nor does relational theory have to overstate its position in order to make the point that the experiential quality of relatedness to others is paramount to mental functioning and personality development. But the emphasis on consciousness, relationality, and intersubjectivity in contemporary theory and praxis naturally challenges the fundamental principle of psychoanalytic doctrine: namely, that mind is the epigenesis and outgrowth of unconscious process. If the relational mind no longer rests on an unconscious edifice, then we have a very different psychoanalytic model from its classical origins.

Stolorow and his collaborators perhaps best represent the tension between the conscious-unconscious binary. Rather than juxtapose unconscious dimensions in relation to conscious experience, and how there are different and competing realms of psychic reality operative at once, relational proponents make ontological commitments about the

nature of mind that are severely encumbered by theoretical biases. For Stolorow and his colleagues, intersubjectivity is ontologically constituted through conscious acts: "experience is *always* embedded in a constitutive intersubjective context" (Stolorow & Atwood, 1992, p. 24, emphasis added). Elsewhere he states that the intersubjective system is the "constitutive role of relatedness in the making of *all* experience" (Stolorow, 2001, p. xiii, emphasis added). Even more recently Stolorow (2010) affirms that "all… forms of unconsciousness are constituted in relational contexts" for "'unconscious organizing principles' are intersubjectively constituted" (p. 7). Notice here that he states that *any* form of unconscious process is intersubjectively—hence relationally—established. This implies that even unconscious drives, which are part of our embodied biological constitutions, are enacted and composed by relational elements; therefore, drives are originally derived from conscious experience. This problematic presupposition goes against contemporary wisdom in the biological sciences. How can the intersubjective system create or co-construct our organic bodies?

These absolutist overstatements lend themselves to decentering intrapsychic activity over relational interaction, and draw into question the separateness of the self, the preexistent developmental history of the patient prior to treatment, the prehistory of unconscious processes independent of one's relatedness to others, and *a priori* mental organizations that precede engagement with the social world.[2]These statements appear to replace psychoanalysis as a science of the unconscious with an intersubjective ontology that gives priority to conscious experience.[3]To privilege consciousness over unconsciousness, to me, appears to subordinate the value of psychoanalysis as an original contribution to understanding human experience. Even if we as analysts are divided by competing theoretical identifications, it seems difficult at best to relegate the primordial nature of unconscious dynamics to a trivialized backseat position that is implicit in much of the relational literature. For Freud (1900), the "unconscious is the true psychical reality" (p. 613), which by definition is the necessary condition for intersubjectivity to materialize and thrive.

Although there are many contemporary analysts who are still sensitive to unconscious processes in their writings and clinical work, it nevertheless appears that on the surface, for many relational analysts, the unconscious has become an antiquated category. While Stolorow, Atwood, and Orange have certainly advocated for revisionist interpretations of unconscious processes, Stolorow (2001) in particular specifically relates a theoretical sentiment that is common among many relationalists: "In place of the Freudian unconscious…we envision a multiply contextualized experimental world, an organized totality of lived personal experience, *more or less conscious* (p. xii, emphasis added). Here we have a radical departure from Freud's original contributions to psychology.

Developing a Relational Treatment Philosophy

By contemporary standards, I would be said to favor relational and existential orientations to practice informed by my training in self psychology, the interpersonal schools, and phenomenology; but unlike any identification with a particular theoretical movement, this acknowledgment carries forth certain stipulations. Given my dual training background in

clinical psychology and philosophy, I never liked being classified or pigeon-holed into a certain theoretical camp because this tends to limit the scope of self-identity and professional perception as well as dilute the rich and multi-textured conceptual body the psychoanalytic domain serves to offer as a whole. Although I largely work clinically as a relational therapist,[4] I may be more accurately considered a comparative analyst heavily indebted to many great intellectuals, practitioners, and contemporaneous trains of thought. Among these, first and foremost is Freud, who has been greatly misunderstood and maligned by relational schools today. Many of his theories have been fundamentally misinterpreted and distorted from their original context, nor critically evaluated within the evolution of his mature theoretical corpus.[5]This is due in part because few have bothered to consult his original texts written in German and have been conditioned by incompetent expositors and introductory textbooks that have little appreciation for accurate scholarship. Therefore, I am not in agreement with the uncritically accepted and erroneous characterizations of Freudian theory as adhering to a one-person psychology (Greenberg & Mitchell, 1983; Mitchell & Aron, 1999) or espousing the belief in a solipsistic, isolated mind (Stolorow & Atwood, 1992), just to name two popularized propaganda circulating today. In my opinion, these claims are invalid, fueled in part by ignorance about what Freud actually said, including the corruption of classical thought by Anglo commentators that is carelessly perpetuated in contemporary training institutes, as well as political idolatry advocated by the American middle group of relational psychoanalysis who are radically opposed to classical paradigms.[6] By the subjective accounts of his patients (Lohser & Newton, 1996; Roazen, 1995), Freud was quite relational, personable, and flexible in his approach to treatment; but unlike some relational clinicians today, he turned a critical eye toward continually uncovering and understanding the myriad unconscious processes that suffuse the analytic encounter including the interpersonal dynamics of resistance, transference, repetition, and working through. Although I do not wish to belabor points of contention between relational and classical thought, suffice it to say that I do not see the radical divide that is professed to exist. Where important and valid discrepancies do exist, they tend to lie in the nature of specific theoretical disputes and renunciations, (e.g., feminist psychology), extensions, and revisionist expansions of technique, which are something radically different than the broad philosophical and technical innovations embedded in the classical tradition that relational perspectives seem to discredit. As I have said elsewhere, psychoanalysis is merely a footnote to Freud (2004a).

I cannot emphasize enough the need for beginning therapists to develop a firm theoretical orientation to their work and to be able to justify its merits and limitations. While there is often a schism that exists between theory and practice, your theoretical orientation guides you on how to think conceptually about case material and informs your approach to treatment. Theory and method are not necessarily synonymous, and they are often confounded to mean one and the same thing. In practice, however, the clinician is informed by multiple perspectives at any given moment, and therefore must be open and flexible to seeing points of connection between the patient's reported lived subjective reality and the diverse theoretical models that may be applied in attempting to lend order and meaning to that process. Beginning therapists need to develop a firm grasp of their

theoretical orientation(s) and preferred modes of working clinically for the simple reason that it provides structure and direction for informed therapeutic practice. Whatever preferred modes of conceptualization one adopts in the end, the clinician can never escape from the fact that theory only serves as an orienting guide to the treatment process that is constantly being challenged and confronted by emergent data and the intersubjective contingencies that arise in the lived encounter. Just as theory takes on its own dynamic, thus introducing contradiction, evolution, and change, so does the therapeutic dyad itself informed by the psychodynamics and phenomenological novelties of forming a new relationship amongst strangers. When it comes down to it, you and the patient are thrown into an unfamiliar encounter, each with one's own competing subjectivities and individual personalities. This is the existential dimension of treatment that cannot be eluded nor disavowed, for it is here that a new intersubjective reality is forged and negotiated.

Existential, phenomenological, and continental perspectives in philosophy complement psychoanalytic discourse, thus providing a fecundity of overlap in conceptual thought and practice that the relational schools have been increasingly acknowledging over the past two decades. It can be said that psychoanalysis is fundamentally a theory and method geared toward insight, truth, and the amelioration of human suffering, while philosophy is the pursuit of wisdom, truth, human excellence, and rational meaning, what Freud (1927) himself identifies as *Logos*. I see these two disciplines as embracing similar convictions that human existence is ultimately about developing our potential, fulfilling our possibilities, and living an authentic life through the liberation of ignorance and the malicious forces that threaten our happiness. This takes courage and fortitude, but it first and foremost takes awareness; for we can only be free through knowledge. In this way, therapy is a *liberation struggle*—Know thyself! This Delphic decree is the psychoanalytic motto. Insight or self-knowledge takes a commitment to educating oneself to what truly lies within—the complexity and competing flux of the inner world—and this is never an easy endeavor. It takes another to nurture and draw this out, to validate and reinforce, to encourage and to guide, to hold and reassure. This begins with the most primary of all relations, the relation of the embryonic self to that of its mother, then to its family and community at large, and finally to the social institutions that foster and beget the cultivation of self-consciousness. This is why a relational approach to treatment mirrors the natural process of self-development, for the self is given over to the other equiprimordially, and the other to the self: the subject-object split is foreclosed. Each are dynamically informed by a dialectical system of mutual implication, interaction, exchange, negotiation, and force.

Therapy as a Way of Being

When I was a pre-doctoral intern in Chicago, I was assigned a training and supervising analyst at the Chicago Institute for Psychoanalysis to supervise two of my cases. When I first met the man, he opened his office door onto a vestibule where I was sitting, which was used as a common waiting area for several other offices. When he called me by name, I stood up and entered his office greeting him with a handshake and a hello. He pointed with his hand to where I should sit and then walked over to his chair and promptly

sat down. He stared at me and said nothing. I was waiting for some sort of an appropriate social greeting, introduction, or question of some sort, but instead I received the cool impression that I was to be observed and analyzed like I imagined he behaved toward his patients. Close to a minute had passed before I broke the ice and began to speak. It was clear to me that I was not going to be treated as a colleague, nor even as an advanced graduate student about to receive his doctorate, but as an object under a microscope. Whether this was the man's personality or his style of clinical supervision, the immediate impression he created was intractable: he was a jerk. Whether he was a brilliant supervisor or not is inconsequential: his very mode of relatedness was enough to create unease, intimidation, and resistance. This was not the way I wished to be treated, and I immediately thought how this too must feel for patients who are in an even more vulnerable situation. Simply put, his behavior was uncalled for and certainly not the treatment approach I wanted to emulate.

There were many instances like this one during my training days where I learned more about how *not* to act rather than about the so-called "appropriate" technique or demeanor I should adopt as a therapist. Ask yourself this question: How would you feel if you were in the patient's shoes? In the real world of private practice outside of the academy, this type of behavior is a good way to lose business: if people are made to feel interpersonally uncomfortable, then they are more likely than not to discontinue coming to treatment because they feel as though you have already judged or demeaned them. It is common throughout the psychoanalytic literature to read of authors who are quick to blame or condemn the patient as being resistant, defensive, acting out, deficient, limited, disturbed, narcissistic, or pathological in some way when they fail to return or commit to treatment, when in turn they may be simply reacting to the normal feeling of being belittled in some fashion—even dehumanized—by a cool, staid, or threatening first impression the analytic encounter can sometimes generate. And dependent and deprived patients will sometimes masochistically submit themselves to this form of treatment with the unconscious hope of winning over their analyst's approval, when in all likelihood this acquiescent submission is motived from abnormal forces dictated not only by transference repetition, but by the recalcitrant need to win recognition from a cold, depriving object in the here and now.

Although the analyst is always a transference figure, s/he can also generate extra-transferential phenomena that may be more of the result of unspoken or expressed power differentials that truly belong to the analyst's pathological inclinations. If you act superior, aloof, removed, and/or clinically detached, then the message is clear: you don't want to get too close. So how could you expect patients to open up or trust you? If you create the slightest impression of being contemptuous, then the patient's "shit detector" immediately turns on and the relational milieu becomes soiled. Putting aside for the moment the notion of projection and transference, you are accountable for how you come across: your subjectivity, demeanor, interpersonal style and accord, and so forth influence the patient's perceptions, defense activations, relatedness patterns, and the negotiation of individuality within the intersubjective frame of treatment. If you don't concede that you bring

something into the picture, then you can erroneously collude with the false impression that the patient is solely responsible for the reaction s/he orchestrates in others, when in actuality this is a two-way relational street.

Therapy is a *way of being*, not some contrived state, nor just another job, role, or hat one puts on only to be removed at the end of the day. I once had a patient whom I worked with for a few years. Approximately a year and a half into the treatment, during a particularly poignant disclosure, I commented on how I felt for her in that moment. In a dismissing tone she told me: "That's your job, you're supposed to." Since we had already reached a degree of intimacy in the therapy, I was surprised at her dismissal and replied: "As if I couldn't possibly, truly care about you." This led to her confession that it hurts when others show her sympathy or genuine concern because she feels that deep down she does not deserve it, so she brushes it away by finding an ulterior motive in the other's behavior. When you develop a genuine relationship with a patient, you cannot help but open-up your own soul to the experience of the other and feel *with* them and *for* them, even though you may not disclose this directly. When this happens, and when it develops naturally—not acted or manufactured—I find this to be an aesthetic supplement and intensification of empathy, what Heidegger (1927) calls care or concernful solicitude, or what Binswanger (1962) calls an extension of love.

I am always suspicious of those who say that they leave their occupation at the office. How can you just turn off your mind? I simply cannot shut off my fundamental orientation toward existence, namely, to think dynamically and critically about most aspects of life, and to open up my emotional world in the process—my total being. Deep understanding gives me a greater sense of purpose and meaning, even if certain discoveries are unsavory or distressing. Regardless of what we encounter or come to know through the analytic process, psychoanalysis makes our suffering more tolerable. Establishing a sound theoretical orientation for treatment efficacy takes thoughtfulness, justification, critical review, and revision. The lazy therapist who is only worried about what to say and not how to think dynamically will be eaten alive by certain patient populations, such as character disorders, and personally embarrassed when confronted with more intellectually sophisticated clients. One needs a personal commitment to ongoing professional development, and that means personal development. It means reading the literature (both disciplinary and interdisciplinary) and critically thinking about your own thoughts and experiences rather than consulting the identified expert on what is acceptable and what is not. Along with introspection and ongoing self-analysis, this critical function is a necessary (albeit not sufficient) condition for lasting professional growth that transcends the ossified dogma that can potentially serve to create stasis and ostracization from actualizing genuine potential.

In many distinct ways, one's theoretical orientation often complements the clinician's personality or individuality, and consequently, what is more often the case than not, the personality of the therapist largely determines the course of the therapy. It is the analyst's personality that allows for genuine engagement, thus making a clearing for authentic

relatedness. One's own personality cannot help but be interjected in every aspect of the treatment, for every disclosure is value laden and communicates a great deal about the clinician, even during silence.

In order to establish and maintain ongoing professional identity, the therapist needs to think critically about their own worldview and adopt approaches that are congruent with that worldview in order to appear trustworthy and credible to patients. Beginning therapists often ask themselves: What do I do or say when the patient says *x* or *y* ?, as if there is a bag of tricks or general skill set to apply to each and every situation when a similar dynamic unfolds. In my experience teaching and supervising graduate students and post-graduate professionals, it appears to be a common phenomenon that what they initially want is a tool bag to reach into in order to fix something in the patient. They have done some reading, have some pat phrases down, are testing out or playing a role, hence trying it on for fit and size, rather than consulting their own personality tempered by thoughtful self-awareness and the process that guides it. Those who take the "bag of tricks" approach will be mediocre at best, and usually stifle the treatment because patients will inevitably feel that they come across as gimmicky, stilted, pedantic, and unnatural. This does not foster genuine relatedness, which is what many patients need, especially those with attachment vulnerabilities, in order to live more fulfilling and functional lives.

Developing a personal treatment philosophy should authentically reflect the way in which clinicians actually live their lives in order *to be* genuine to the patient. Do you really believe what you tell patients? Do you hold yourself to the same standards? If not, you should reevaluate your premises and the reasons that dictate your approach to treatment. Clinical and theoretical refinement demands work, reading, experimentation, thoughtfulness, contemplation, supervised experience, and ongoing training. You are only going to take a person as far as you have been yourself (Erikson,1964). If you can't recognize the dynamic forces that influence your own psychic reality, then how will you recognize what is going on in others? Every conscientious clinician should know thyself, get personal therapy or undergo analysis, and live an introspective and contemplative life. This is both a preparatory and ongoing attitude or sensibility that grounds your theoretical beliefs and convictions, guides your clinical work, and offers stability in professional identity and therapeutic efficacy. This takes time and erudition, experience and technical refinement, openness and flexibility, creativity and humor, and as Kohut (1971) would say, a "modicum" of wisdom.

The Value of Relationality in Clinical Practice

Relational and intersubjective viewpoints have convincingly overturned the dogmatic inculcation of Americanized classical training and encourage free thinking, experimentation, novelty, spontaneity, creativity, authentic self-expression, humor, and play. And here is what I believe is the relational position's greatest contribution: the way they practice. There is malleability in the treatment frame, selectivity in interventions that are tailored to the unique needs and qualities of each patient, and a proper burial of the prototypic solemn analyst who is fundamentally removed from relating as one human

being to another in the service of a withholding, frustrating, and ungratifying methodology designed to provoke transference enactments, deprivation, and unnecessary feelings of rejection, shame, guilt, and rage.

Today's relational analyst is more adept at customizing technique to fit each unique dyad (Beebe & Lachmann, 2003; Greenberg, 2001), what Bacal (1998) refers to as a specificity of intervention choice, and rallies against a blanket standardization or manualization of practice. Because of these important modifications to methodology, one may not inappropriately say that a relational approach can be a superior form of treatment for many patients because it enriches the scope of human experience in relation to another's and validates their wish for understanding, meaning, recognition, and love, what may very well be the most coveted and exalted ideals that make psychoanalysis effectively transformative and healing. In short, unlike the caricature of the classical analyst, the relational practitioner treats the patient as a real person who has needs, conflicts, and wishes that the analyst is obliged to address, and if possible, meet or fulfill simply because it is the humane thing to do.

Traditionalists and contemporary Freudians may have a legitimate criticism that the "new view" analysts gloss over the goal of uncovering unconscious conflicts; but in their defense, they would likely say that uncovering unconscious material for the sake of pure discovery is not as therapeutically important as other pursuits. To be fair to the classicists, however, in enumerating various criticisms, contemporary practitioners by and large could be accused of: (1) not focusing on the deeper stratification of unconscious structure and their dynamics processes; (2) largely failing to focus on the genetic past and their symbolic manifestations in the transference; (3) are inattentive to unconscious fantasy; (4) are too permissive in maintaining a permeable treatment frame, one which largely lacks contained or well-defined boundaries, including consensual rules for participation; and (5) focuses too much on the here and now, where the emphasis is placed on co-constructing a relationship rather than exploring the patient's dynamic past. But, in practice, this is much more likely to be a matter of emphasis.

In response, the contemporary practitioner would likely question the value of unconscious interpretation as a primary therapeutic goal over the lived reality of the present moment that is far more pressing and important to the client. Here, interpretation for the sake of interpretation out of the analyst's need to pursue truth or to be right, to interject self-importance in the session, or to trump the patient's take on their own inner experience is not deemed to be the main mission of analysis. In fact, the principle of the primacy of interpretation that traditionally characterizes the technical method of psychoanalysis could be the very bane of treatment for many patients simply because it is not helpful. Not only can premature or imposed (let alone intrusive), adduced interpretations drive patients away from treatment due to their mis-attunements or stinging exposures based on a lack of tact, they can arguably be clinically counter-indicated. The last thing patients want is their analyst to analyze with a hammer.

The *interpretive imposition*—the calling card of shame—is often an authoritarian epistemology foisted upon the analysand as an illusory objective observation toted under the banner of truth, when it is simply superimposed power on a dubious subject. The personal (sometimes narcissistic) need for the clinician to spew forth gems of wisdom, or point out unconscious motives based on the analyst's internal muses (qua constructive fantasies) and passing them off as so-called quasi-scientific facts, perpetuates a hubris that betrays the spirit of psychoanalysis as a catalyst for self-knowledge. A methodology that privileges interpretation over self-discovery, disclosedness, and unconcealment, what the ancients refer to as *aletheia* (ἀλήθεια), undermines the value of self-exploration as a confrontation with the dialectic of truth and uncertainty.

Since its inception, psychoanalysis has always received criticism for not measuring up to the propounded status of a legitimate "science." But clinical case material is what we mainly rely on as legitimate sources of qualitative empirical data.[7] As Safran (2003) points out in his survey of psychotherapy research, there are many empirically derived conclusions that address the question of treatment efficacy. Once taking into account the patient's developmental and life history, we may be alerted to the following conditions that remain the major criteria in which to evaluate the merit and/or limitations of a treatment and the specific interventions employed: the (a) qualitative degree of the working alliance, including (but not limited to) the level of trust and capacity to form an attachment with the analyst; (b) mutual agreement with regard to the process and goals of treatment; and (c) the patient's assent to professional authority as indicative of his or her level of satisfaction (with or without symptom improvement). In the end, what is likely most indicative of clinical efficacy is whether or not the client likes the therapist and feels safe in the treatment.

As I have stated elsewhere (Mills, 2005b), in my opinion psychoanalysis is ultimately about process over anything else—perhaps even above technical principles, theory, and interventions—for it relies on the indeterminate unfolding of inner experience within intersubjective space. In our training we learn to cultivate an analytic attitude of clinical composure, optimal listening, data-gathering, hypothesis testing, critical reflection, clarification and reevaluation—all of which conceptually and behaviorally guide the analytic process. Process is everything, and attunement to process will determine if you can take the patient where he or she needs to go. The analyst has the challenging task of attending to the patient's associations within particular contexts of content and form, perpetuity versus discontinuity, sequence and coherence, thus noting repetitions of themes and patterns, and the convergence of such themes within a teleological dynamic trajectory of conceptual meaning. The clinician has to be vigilant for competing, overlapping, and/or parallel processes that are potentially operative at once, thus requiring shifts in focal attention and microdynamic attunement. There are always realities encroaching on other realities, and affect plays a crucial part. Observation becomes a way of being that requires listening on multiple levels of experiential complexity—from manifest to latent content; detecting unconscious communications; recognizing resistance, defense, drive derivatives (i.e., unconscious desire), transference manifestations, and differential elements of each compromise; tracking the dialectical

tensions between competing wishes, fantasies, and conflicts with close attention to their affective reverberations; listening at different levels of abstraction; ferreting out one's countertransference from ordinary subjective peculiarities—to tracing the multifarious interpersonal components of therapeutic exchange. Given such complexity and the overdetermination of multiple competing processes, I hardly think psychoanalytic technique is capable of being manualized by following a step-by-step method.

What patients remember the most about you is not necessarily what you say, but how you relate to them, how you model a way of being; and this is what gets internalized and transmuted within psychic structure. No one wants to be related to as a thing. Traditional approaches, whether intended or not, implicitly foster (if not encourage) a detached scientific, experience-far observer paradigm, while the relational approach sees the inherent value of being real, genuine, and fostering an experience-near, co-participant observer stance, whereby the patient is related to as a non-objectified person.

It becomes difficult to define the overall purpose or meaning of therapy because the clinical encounter is always mediated by context and contingency. For rhetorical purposes, if I had to pinpoint the essence of treatment, I would say that therapy is a *process of becoming*, a process of creative self-discovery, a process that requires the presence and influence of the other. Therefore, therapy is about forming and being in a relationship, one that is healthier and more genuine than what patients know only too well in their private lives. Having the opportunity to say what they truly think, and feel how they truly feel, is one of the most beautiful experiences and more curative dimensions of analysis, and having this recognized, understood, and validated by another person serves to encourage and instil a new set of values and ideals for what it truly means to have a fulfilling relationship. When this occurs naturally and developmentally over time, the patient comes to identify with and pursue a new way of being that is modeled on authentic relationality.

Endnotes

[1]IARPP Website, About Us: Who We Are. http://iarpp.net/who-we-are/ Downloaded on January 22, 2016.

[2] Although Stolorow, Atwood, and Orange have defended their positions quite well in response to their critics, often correcting critics on facets of their writings most readers—let alone sophisticated researchers—would not be reasonably aware of without going to the effort of reading their entire collected body of combined works, one lacuna they cannot defend in their intersubjectivity theory is accounting for *a priori* unconscious processes prior to the emergence of consciousness, subject matter I thoroughly address elsewhere (see Mills, 2002a, 2002b). Although having attempted to address the role of organizing principles and the unconscious (Stolorow & Atwood, 1992), because they designate intersubjectivity to be the heart of *all* human experience, they commit

themselves to a philosophy of consciousness that by definition fails to adequately account for an unconscious ontology, which I argue is the necessary precondition for consciousness and intersubjective life to emerge (Mills, 2010).

In their criticism of my assessment of their philosophy, Stolorow et al. (2006) claim that because I do not adequately situate the context of their writings when quoting or interpreting their work, I "annul" the notion of the unconscious in their combined theories, which they uphold. But this is not accurate. Although they account for the notion of the unconscious, it becomes decentered, not annulled. They do not deny the significance of the unconscious, they simply privilege conscious experience, to which they give priority due to the primacy of intersubjectivity. Although I readily concede that the authors object to being equated with other relationalists who do not adequately address the nature and being of the unconscious in contemporary discourse, Stolorow et al. still bear the onus of explaining their own textual contradictions.

[3] Freud (1925) ultimately defined psychoanalysis as "the science of unconscious mental processes" (p. 70).

[4] I wish to distinguish myself from some forms of clinical practice that are common among relational analysts today including the over-expression of personal communications, countertransference disclosures, and the insistence on reciprocal revelations that may reveal more about the needs of the analyst rather than the patient's. I am much more conservative when it comes to these matters and am cautious about the risk of too much self-disclosure.

[5] These issues are explored in depth in *Rereading Freud: Psychoanalysis through Philosophy* (Mills, 2004a) and *Psychoanalysis at the Limit: Epistemology, Mind, and the Question of Science* (Mills, 2004b).

[6] While I do not intend to provoke enemies among my respected colleagues over theoretical turf wars, I do feel it is vitally important to be open to self-critique within any preferred camp throughout the history of the psychoanalytic movement in order to be able to prosper and advance psychoanalysis as a whole. Even though I readily concede that I practice as a relational clinician, I am not so impressed with the need to elevate relationality by vilifying classical approaches.

[7] I am not in agreement with Masling's (2003) claim that clinical data is "not empirical" (p. 597) since it relies on the qualitative enactments and analysis of experience, not merely culled from the analyst's clinical phenomenology, but also empirically investigated by psychoanalytic psychotherapy researchers including Gill, Hoffman, Luborsky, Strupp, and Safran, just to name a few.

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