Whatever Happened to the Cat?—*Interpersonal Perspectives on the Self*

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I WANT TO BEGIN WITH A clinical example from Gill's and Hoffman's (1982) book on transference. This is an excerpt from a young woman's session with a "classical" analyst, committed to silence; or, perhaps intimidated into silence by the recording of the session.

> *P: You know, it is true that my pets were consistently taken away from me. The bird was, the cat was, the rabbit was. And my sister's cat killed my turtle, and one of my goldfish ... the two smaller, the incidents that occurred when I was smaller—the bird and the cat—I never did understand. It seemed to me a question of convenience; the rabbit I understood, because I was going to camp, and my mother just didn't want to be bothered taking care of a rabbit over the summer. Also I expect they were going away for awhile. But the bird, which we had when I was very small, under three, was given to my grandmother. I don't know why. And he died. And the cat was left in R [place] at the end of one summer, ostensibly because he was hiding in the furnace room, and my mother just didn't feel like crawling around on pipes and fishing him out. And also maybe she felt a little guilty. I suppose she thought that he was very happy there and that he would be miserable back in the apartment, which was no doubt quite true. But I was very unhappy about that; it seemed, uh, wrong. He was my cat or so it had been proclaimed. ... There's something about that cat, I guess, but I [sigh] I don't know exactly what. There are, I suppose, about fifteen things about that cat, and I don't know which is important and which isn't or what it all means.*

What follows is the authors' gloss of the session with a special emphasis on transference: "The patient's sense of puzzlement at her parents' behaviour and her feeling that she was treated unfairly by them seems to parallel her experience of the immediate interaction with the therapist. He, too, she must feel, leaves her to divine by herself the reasons for the deprivations she is called upon to endure. In the current situation, she again tries to rationalize his silence by reference to the possibility that there is something wrong with her associations: they may lack significance. Of course, she is also implicitly complaining about his failure to help her establish where the significance lies. One could also speculate that she identifies herself with the cat which the mother (analyst) doesn't want to crawl around on pipes to fish out (rescue from her perplexity by an intervention)" (Gill and Hoffman, 1982, p. 16).

But, what really happened to the cat? Was the poor beast left to die in the basement? Unlikely. Was a window left open? Did a neighbor pick it up later? Did it stay in the basement until they returned the next weekend? They seemed to be leaving at the summer's end. Was the poor cat ever seen again? Is she making up the whole story to indite her mother, the abuser of children and pets? Or, is this an example of a common enough, if deplorable phenomenon, people who desert their pets at the end of a summer, leave them to fend for themselves, become feral?

These seem to be the questions analysts don't ask; that is, what are the relevant data of this patient's experience in "real life, " out there: "What's going on around here?" rather than the more usual psychoanalytic inquiry into "what does it mean?"

Can a patient's real life be seen as simply a precipitating locus for a fantasy system? Is the patient distorting her life? Is she misreading what occurred, a distortion of the present based on past experience? Or, could it be that the patient is mystified by present experience, cannot comprehend her mother's casual disavowal of what the patient loves, wonders about her own dispensibility. Is her present experience perhaps not so different from her past experience, both in the pattern of actual events and in the patient's inability to fully conceptualize and negotiate successfully with what is happening in her world?

The analyst doesn't think to ask. This same strange diffidence about actual events is present in a dream I shall present later, and recurs strikingly in the transference and countertransference implications of that dream. Why should this be so? Is the same mystification ocurring in the relationship with the therapist? Why is the "manifest content" treated in so dismissive a way? Why do we leap to abstractions about what things "really" mean? Why aren't appearances enough? Well, perhaps as Oscar Wilde put it, it's "Only superficial people who insist on looking beneath the surface."

Viewed somewhat less presumptively, I think it has to do with the consequences of what remains, to my mind, the crucial issue which both defines and divides psychoanalysts, namely the perception of reality—both the patient's and the therapist's. The formal, familiar dichotomy of intrapsychic/interpersonal distinguishes what goes on in the patient's head from what goes on in the patient's world. The intrapsychic perspective presumes that the patient distorts reality out of drive or early experience-motivated fantasy. The interpersonal perspective presumes that the patient distorts experience in an attempt to grasp reality. That is, for the intrapsychic, distortion is a misrepresentation of the world; for the interpersonal, distortion is a valid representation of the world, the interpersonal, distortion is a valid representation of the world, a caricature, to be sure, but a telling approximation.

I once heard a noted classical analyst offhandedly say at a meeting, "There is really no problem. The interpersonal is where the intrapsychic plays itself out"; i.e., it is the playground for the fantasies. The interpersonalist would reply, "To the contrary, the intrapsychic is merely an interpolation of the interpersonal; it is what the mind makes of interpersonal experience"; the real world is outside and it's the real world which is troubling the patient.

No one would deny, of course, that the real world exists or that the mind has its ways, but does the infant develop first, internally, in isolation, only later becoming social and interactional? Or, is the infant interactional from birth or before, becoming human by virtue of its capacity to interact from the very beginning? Does it make any difference? One wonders—as Humpty Dumpty put it—if it is simply a matter of whom is to be master, the speaker or the concept.

But it is not simply a metaphysical debate—how many analysts can stand on the head of a pin (quite a few). There are, in this debate, profound and I think irreconcilable consequences for that erstwhile object of our attentions, the patient. Nowhere are these differences more evident or more illustrative than in the concept of the self as self psychologists and interpersonalists use it.

Of course, the self is not an invention of psychoanalysts: it has been around as long as the concept of consciousness. It is also well known that Freud's "Das Ich" translates more accurately into "I" or even "self" than that pseudoclassical conceit, "the ego"; and that issues of the self have undergone extensiveperusal throughout psychoanalysis[1]. But the radical use of self as the arbiter of reality really first appears inmainstream psychoanalysis with Fairbairn, Winnicott's true self and Kohut's cohesive self.

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[1]See Tuttman for an extensive discussion of this issue (1988).

The use of the self by Kohutians has been extensively defined. Sullivan, too, has an elaborated concept of the self. But interpersonal psychoanalysis now contains a number of glosses on Sullivan's position, certainly extrapolations, but not necessarily ones Sullivan would have agreed with nor approved of. Of course, no one remains happy with his/her disciples. Some cynic said that a man gets the disciples he deserves. Freud certainly didn't remain happy with his. Nor, according to Gedo, did Kohut who complained "bitterly" about the directions some of his followers were moving his theory (Gedo, 1987). Perhaps Sullivan would disown my particular extrapolation of interpersonal analysis, but as Jean Cocteau put it, each poet sings from his family tree, and mine is sullivanian.

I do believe that in the present ecumenical effort to establish a unified "relational" vs "drive" rubric by Greenberg and Mitchell, Sullivan, and interpersonal psychoanalysis have been subsumed and subtly subverted (Greenberg and Mitchell, 1983). There remains a powerful conceptual difference between interpersonal psychoanalysis and the "relational" groups of object relations and self psychology. What is unique about interpersonalism is difficult to grasp because it requires a shift in a very pervasive set of assumptions about the very nature of reality. Intrapsychic and interpersonal perspectives are not really perspectives on the same reality. Rather they are entirely different realities.

It must be understood that although Kohut's self deals with interpersonal experience, it is essentially an intrapsychic structure. It may be a bridge between intrapsychic and interpersonal theory, but it is far from interpersonal. To quote Kohut, "[We] do not focus on the content of experiences, but on the ways by which a specific psychological structure, the self, is laid down. In analysis, … we observe the reactivation (in the form of self-object transferences) of structure-building attempts that had been thwarted during childhood" (Kohut, p. 173). As Greenberg and Mitchell put it, "Kohut continually emphasizes (drawing on his theoretical heritage in classical ego psychology) not therelationship per se, but the manner in which the relationship affects the self-experience." (p. 365). The paradigmremains intrapsychic.

The cause of psychopathology is perceived to be chronic failure in empathy, attributable to parental character pathology, which undermines the healthy development of the child's self. Parental figures, by over or understimulating the child fail to provide sustenance. From this viewpoint, narcissistic psychopathology is very much, like scurvy, a deficiency disease, capable of replacement therapy; albeit with some permanent sequelae. But one is left with the sense that, to quote Greenberg and Mitchell again, "there is never any actual engagement between the parent and child, any encounter between real as opposed to inflated and idealized people" (p. 371). Not much attention is paid to the nuances of the deprivation. The final common pathway—the deprivation and consequent deficit of the self—is what matters.

Sullivan, on the other hand, operated out of a superordinate interpersonal theory of child development in which the child develops humanly *in* interaction with others. For Sullivan, the self develops as an instrument of interaction with significant others, to mediate the developing person's needs for what he called satisfaction and security (Sullivan, 1940). Sullivan was, until his later years, rather inconsistent in his use of terms like "self", "self-system, and personality" (Greenberg and Mitchell, p. 97). Barnett elaborates two aspects of the self: the *representational* and the *operational* (Barnett, p. 401). The former, the representational, is the intrapsychic reflection of the self. It is what Sullivan called the personification of the self. (Greenberg and Mitchell, p. 97). "Good me" and "bad me" are such personifications, internalized self-assessments; but they remain essentially strategies for negotiating successfully with significant others in the milieu. They are internalized maps for the dangerous territory of living: if I can avoid being "Bad me", mother will not get upset, she will love me.

Barnett's operational self, the aspect of the self that deals with the outside world, Sullivan limited to what he called the "self-system". It is the self as agency. This is very similar to, and likely derived from George Herbert Mead's distinction between "me" and "I": it is the "I" (operational) who mediates in the world for the "me" (representational) (Aboulafia, 1986). For Sullivan, what makes the caretaker anxious, makes the child anxious

and the overwhelming experience of this "contagious" anxiety is avoided through the development of the "self-system", really a specialized alarm system. To quote Greenberg and Mitchell, "It is a vast system of processes, mental states, symbols and signs of warning, operating to minimize anxiety" (p. 97). For Kohut experience is in the service of the developing self: for Sullivan, the self-system is developed to survive experience.

In contrast to the Kohutian self which is nurtured by relatedness, the Sullivanian self-system *obstructs* relatedness and clarity, stands in the way of "syntaxic", clear communication. It is a device to reduce anxiety at the price of clarity. To quote Greenberg and Mitchell, "Sullivan's definition of the self-system solely in terms of its antianxiety function has left a gap in his theory regarding the organization of the self in nonpathological functioning" (p. 114):

Living just beyond this Dew Line, this Early Warning System, is a network of strategies and contrivances for dealing with the perceived dangers of the world. A way of being-in-the-world which is idiosyncratic, highly creative, and powerfully redundant; that is, capable of provoking the other people in the patient's world to react in predictable and controllable ways—not, one notes, necessarily gratifying or rewarding ways. Is this still the self-system or has it become personality or character? Suffice it to say that one cannot easily conceptualize a defense system which only warns and inattends or dissociates, and does not have a dimension which plans strategies in the real world.

Sullivan did make a distinction between personality and self. To quote Greenberg and Mitchell, "One's personality is what one is; one's self is what one takes oneself to be. And, what one takes oneself to be is a matter of reflected appraisals, that is, what other people take you to be" (Greenberg and Mitchell, p. 96). Personality, then, is the sum of all one is—conscious, dissociated, inattended, rational, parataxic, autistic, whatever. The self is the top of the iceberg, a shifting amalgam of self-awareness. The self is who I think I am and it designates what I shall notice or not notice about the world around me.

Self and self system are therefore not held to be synonymous. Sullivan was not interested at all in the unique self, individuality, although he was certainly interested in personality. This lapse was critically assessed by Fromm and, is to this day, bitterly debated among post-sullivanians. It is very evident in Sullivan's clinical work that he paid exquisite attention to the nuances and idiosyncrasies of individual experience. But he was interested in individual experience, not *individuality*, which he considered either an illusion, or at the very least, an area too private to be accessible to psychotherapy. Sullivan would have been amused by the conceit in Woody Allen's movie, the parrot who sings, "I've gotta be me".

This ordinary usage of "self"—precious, unique me—what we all intuitively believe self to be, is of no great interest to psychoanalysts who, like all good scientists, seem to be more interested in what is held commonly, than what is unique and different. So "self" becomes, for Kohut, a signifier of either an intrapsychic structure or for Sullivan an interpersonal defense, but as I shall suggest in the dream presented later, what is uniquely creative is disavowed.

It's of some consolation that unique selfhood gets a good deal of neurological support. In Sachs' lively book, he describes several right-brain damaged patients who have lost their sense of self, who function perfectly but as automatons, what he calls "de-souled" (Sachs, 1970). Also, as Rosenfeld has pointed out, contemporary theories of brain functioning suggest that rather than developing fixed anatomical connections, each brain "wires" itself, in response to stimuli, in ways which are original and unique (Rosenfeld, 1988). So, uniqueness may be real, not illusory, a possibility I must say I find heartening.

To review—however one views the self, it remains that part of the mind which negotiates reality. Moreover, what reality *is* differs markedly in the Kohutian and Interpersonal versions. At first glance, reality seems like an issue of stunning obviousness since, after all, almost all psychoanalysts believe that patients distort, indeed that distortion is the very essence of "patient-dom". Regression, condensation, displacement, compromise formation—the mechanisms of defense in Freudian theory—all result in distortion. And, for Sullivan, parataxic distortion was at the heart of problems in living. To quote Witenberg et al, "It is in essence the goal of psychoanalysis, the rediscovery of the self-system in its entirety, to the end that with the bringing of "bad me" and "good me" into awareness, they may be seen as archaic and currently irrelevant organizations and may be exorcised as personal demons which no longer exist" (Witenberg et al, 1959). This sounds very much like the classical view

of cure as the correction of reality distortions. And yet, with Sullivan, one gets the impression that cure requires, not simply the extirpation of inappropriate self-representations, but the development of a sophisticated and subtly attuned way of being-in-the-world. "No one has grave difficulties in living if he has a very good grasp of what is happening to him" (Sullivan, 1954).

True, patients distort. But, as I said earlier, there are divergent views on the relationship of distortion to reality. I believe that for the intrapsychic theorists, reality is a given, something simply out there which feeds, or fails to feed, the self. For the interpersonalist, it is a construct, a selective reading. As William James put it, reality is a "theater of simultaneous possibilities" (James, 1981) from which the patient and the therapist make their own idiosyncratic selections. If this be so, then the world may well—without prejudice—seem different to different persons. As Stolorow said, "A basic and largely unchallenged philosophical assumption that has pervaded psychoanalysis since its inception is the existence of an "objective reality" that can be known by the analyst and eventually by the patient" (Stolorow, 1988).

Of course, a cow is a cow. But whether it looks like dear Bossie, a ferocious beast about to charge, or the reincarnation of one's uncle from Poona, lies in the eye of the beholder. Accordingly, to use Gill's words, "The patient's experience is not correctly construed as a distortion of current reality in any simple sense, but is rather an idiosyncratic construction of that reality with its own kind of plausibility" (Gill, 1988). Therapy, rather than being a consensual validation of reality becomes a consensual validation of a consensual validation; that is, that the patient does not see the world the same way the therapist does. This distinction encompasses the difference between empathy and symbiosis; empathy recognizes the gap between people, the privacy of experience. It respects the difference in the way you and I see the world. Symbiosis, on the other hand, implies a complacent continuity of experience: since I know what *I* feel, I know what you feel or ought to feel.

There are some very tricky nuances emerging from this issue. Kohutians would claim that they pay meticulous attention to the private reality of the patient and indeed they do. Yet, it is my contention that it is on this issue of reality and distortion that Kohutians and Interpersonalists part ways, and that their common investment in The Self obscures how differently this term isused by each, leading to quite variant visions of the therapeutic process.

A brief clinical excerpt may help clarify this issue. Kohut reports:

If a patient tells me how hurt he was because I was a minute late or because I did not respond to his prideful story of a success, should I tell him that his responses are unrealistic? Should I tell him that his perception of reality is distorted and that he is confusing me with his father or his mother? Or, should I rather say to him that we are sensitive to the actions of people around us who have come to be as important to us as our parents were to us long ago and that, in view of his mother's unpredictability and his father's disinterest in him, his perceptions of the significance of my actions and omissions has been understandably heightened and his reactions to them intensified? (Kohut, p. 176).

Really, what is that saying? That the therapist understands but that the patient is wrong, distorting reality. Moreover that the therapist is validating the patient's early experience with a non-empathic parent, but disallowing the patient's present experience with him. The therapist is the arbiter of reality. But a number of questions arise. Is the patient now having an allergic reaction to disappointment? If the patient is distorting his present experience, why not his past? Perhaps, he was as touchy and unforgiving then as he is now. Maybe Kohut is getting a taste of what it was like then to deal with him. Perhaps his father neglected him because he was not permitted (by the mother?) to engage his son, albeit angrily.

Or, since the therapist places such value on empathic contact, why *is* he late, why *is* he inattentive? Why has his empathy lapsed? Is there something about the patient which bothers him? Certainly, we see such instances in therapy wherein failure of empathy is an *act* not an omission. Empathy can be an error if one is determined to be empathic. Is the patient wrong to get annoyed? Does it matter? Whatever Kohut says to the patient, won't he be a little more careful next time, a little more attentive? Won't that be mutative? Or, is this perhaps the encroachment of the dreaded "corrective emotional experience", curing the patient by manipulating the transference?

Another therapist makes some structural changes in his waiting room. A patient becomes quite angry and upset. Why is the patient so irrational? Psychodynamics explain. As the Sufis say, no problem is too difficult for a theoretician. Yet, this was the one patient the therapist forgot to tell that the construction would be taking place

Moreover the construction (done over a weekend so that it was by session day, a *fait accompli*) removed a large piece of the waiting room to make an additional room in the apartment next door, where the therapist lived with his wife and recently arrived baby, whose arrival had necessitated the construction. The patient, entering the modified suite, is confronted with a smaller waiting room with a new wall with two doors. As in Bluebeard's castle, one dare not inquire what lies beyond the locked door. The therapist knows something about the patient he does not know he knows: the patient knows something about the therapist she does not know she knows. Or, perhaps as R. D. Laing would put it, she knows better than to know what she knows she is not supposed to know (Laing, 1965). So, it is not so simple. The literature is replete with examples of analysts assuming that their view of reality is veridical, the right one, and that the patient is distorting. How can one be so sure? After all, analysts carry their own psychopathological baggage into the treatment room. As I've said, the restoration of the self, for Kohutians, requires meticulous attention to the patient's experience, to his/her "psychic reality". Kohut, I believe, retained a certain uneasiness about the relativism inherent in this concept. In his posthumously published book, he reaffirmed his belief in confrontations, discretely used. Speaking with some reservation of his more radical proponents, he said, "The self psychologist does not confront the patient with an 'objective' reality that is supposedly more 'real' than his inner reality, but rather confirms the validity and legitimacy of the patient's own view of reality, however contrary it might be to the accepted view of reality held by most adults and the society at large" (Kohut, 1984, p. 173).

Please note the *obiter dictum* of the last phrase, contrary to the *accepted* view of most *adults* and the *society at large*. Kohut says that for the purposes of therapy (which requires a sustained empathy) the patient's view of experience must be grasped by the therapist and reflected accurately. It does not really matter whether it is distorted or not. But, there is a silent caveat: the analyst does not really believe the patient. He/she knows better. The agreement is to treat the patient's "psychic reality" (an oxymoron, if ever there was one) as veridical is a therapeutic ploy, a suspension of disbelief, a device. This implicit humoring of the patient has some interesting consequences for transference and countertransference.

As Friedman comments, "Uncertainty about what is illusion is the heaving sea on which therapy floats" (Friedman, 1988). For my particular version of interpersonalism, acceptance of the patient's reality is not an act of nurturance, but of conviction. As Sullivan pointed out, we are participants in what we observe. We change it by our participation and are changed by it, in turn. The therapeutic act is not a therapeutic attitude, but the meticulous examination of how we interact, what we see and do not see, what we do about what we say to each other.

We have a real person in the room with us, impinging on us in a real way, and calling forth from us a real participation. As Hoffman described this radical perspectivism (not relativism), "[There is] a perspective that has become the basis for a new treatment model, one that takes the analyst's participation into account in a manner that marks a radical departure even within the interpersonal movement where the soil for the development of this model is most fertile. It is a development which is being fueled by and is fueling related developments in many fields of inquiry" (Hoffman, 1987). As analysts, we have become in the poet Marianne Moore's wonderful line, "Real frogs in imaginary gardens".

I want to go on to a clinical example, a dream from Kohut's last book, which I hope will illustrate the points of difference in a Kohutian and Interpersonal vision of the self and its vicissitudes2.

Kohut uses it to elucidate his position about unconscious anger, and indeed it does. But the relationship between cause and effect in psychoanalysis is obscure, to say the least. Psychoanalysts depend on contiguous effects: they do a lot of things at the same time and hope they work. So, one's best effects can be incidental to one's intent. I would like to suggest that Kohut's effectiveness, in this account, may have depended on a more profoundly interpersonal dimension of his relationship with the patient than he suspected.

> *A colleague whom I had analyzed for a number of years told me, as he reflected on what he had achieved during the treatment, that it was "ironical" that while psychoanalytic scuttlebutt had it that self psychologists underplayed human aggression and hostility (supposedly by being too "nice" to their analysands), it was in the analysis with me and not in*

his training analysis with an analyst who repeatedly and insistently confronted him with the evidence of his hostility (especially in the transference) that he had for the first time experienced—deeply and fully—an intense wish to kill. And, he told me, in retrospect, of an analytic session long ago (I believe it was a year or two into his analysis) when he experienced this wish for the first time—at least for the first time with unmistakable intensity. It occurred in the aftermath of an analysis of a dream—not a "self-state dream" I should note, in view of another set of misapprehensions about self psychology which has come our way—on which we had been working for several sessions. The dream in question had taken place in a city block not far from my office. The patient observed a frail man walking along the block that led to a broad boulevard where a statue of a husky, muscular, proud warrior on horseback stood. As the patient watched the man walking along slowly, unsteadily, and weakly, he noticed that the man was not real but some kind of straw doll. Overcome with anger, the patient plunged a knife several times into the straw doll man. To his amazement—there was no evidence of guilt or horror about the deed in the dream—thick red blood flowed out between the straw (Kohut, 1984, p. 138).

Kohut says that the analyst patient, in his prior training analysis, had had similar dreams and the analyst, after listening to his associations, interpreted Oedipal hostility and "encouraged the patient to contact those feelings in the transference". The patient could not contact a genuine wish to kill the therapist, only "moderate conscious anger" at the therapist for not being able to help him. One does hope that Kohut wondered if perhaps the patient was not making a "strawman" of his previous therapist. The interpreting seems so banal and listless.

Kohut does something different in his interpretation: he focuses on the patient's real experience with his chronically ill father who died when he was eleven, and his transferential perception of an ill and enfeebled therapist. The interpretation was that, "the patient was still trying to get to a strong father (the statue of the man on horseback) and that he was disappointed and frustrated because I was not such a father". Kohut implies, but does not make explicit, that the patient may have been reacting to real factors in his "transferential" response to the therapist as weak and ill.

The patient is able to come into touch with his rage at his father, what Kohut calls the "wish to get rid of the sick and depressed father". Note that a repressed wish is still implicit. Kohut's interpretation, far richer than the first analyst's reductive formulation, utilizes intrapsychic fantasy and the real interpersonal experience previously ignored. It focuses the transference in a much more integrated way. The interpretation also permits the patient to "look at" the therapist and to validate, without fear of destroying him, the possibility that the therapist may, too, be ill and lacking in "emotional vigor". Clearly this formulation of Kohut's delves far deeper into the particulars of the patient's life; his universal fantasies to be sure, but also the idiosyncratic life experiences which have shaped his defenses.

Yet, supposing one inquires further into the particulars, the details. After all, as Confucius said, true virtue lies in the asking of questions. Dreams, I think, usually demonstrate a dialectic between this and that—two polarities of the same metaphor. Here it is *lifelessness* ; the statue and the strawman are both effigies. One is, however, very powerful, perhaps dictatorial and to be admired or feared (the proverbial Man on Horseback). The other is feeble, slight, but equally unreal, a strawman. If the metaphor is lifelessness, the polarities are between the relative powers of the effigies, but also between bloody and bloodlessness. In rage, the patient plunges a knife into an effigy, a strawman (one set up to be easily defeated) and discovers to his amazement (but not horror) that the effigy bleeds! In short, the patient is amazed to discover that the strawman is human, after all. Kohut makes no point at all of the patient's surprise at the blood; rather he focuses the issue of rage.

What more likely effigy is there than the therapist—set up in the transference as either dictator or weakling—but in either case defined as a figment of the patient's imagination. Could one not postulate that the dream means exactly what it says; namely, that the patient is amazed that the therapist is real, that he can be hurt, that he is vulnerable. Is it possible that in the previous session, the patient had "gotten to" Kohut, perhaps hurt him? Could the patient's problem be, not his rage *per se*, but his sense of impotence, his inability to have any effect on a therapist who insists that he is not really seen by the patient, that what the patient dreams is his fantasy projections?

The patient, then, expects to rage at the strawman, but does not expect to draw blood. What possible meaning could anger have if it is directed against an unreal person? Real affect *always* must imply an authentic risk: to feel is to be endangered. Perhaps the effectiveness of Kohut's interpretation depended more on his covert admission of participation and vulnerability than on his doctrinaire correctness.

What would have happened if Kohut had asked the patient about his sense of the therapist's vulnerability? Perhaps the patient might have recalled a moment of panic in a previous session when he felt he had penetrated the therapist's neutrality. Would this not be, in Sullivan's terms, empathically communicated anxiety? Would not the "self-system" of the patient operate to "inattend" this event caused by the "Bad Me"? Kohut, by his strong and assertive interpretation traps the patient in a paradoxical bind: the therapist is showing strength by tactily admitting to a weakness. The analyst bleeds—but not very much! A subtle countertransference may be at play.

I have taken the manifest content, the particulars of the dream much further than did either the first training analyst or Kohut. But, it seems to me that this is the essence of Sullivan's concept of the detailed inquiry. As one engages and enriches the textual quality of the inquiry, it does not become, as one might expect, more diffuse and confusing, but focuses the issues of transference and countertransference (Levenson). The very pursuit of specifics opens the door to the relationship with the therapist, since one can hardly inquire into anything without bringing oneself into it. What one chooses to ask about or respond to is an interpersonal event. To talk with someone is to behave with him.

One could stop there: in Kohut's case, it would have been established that the patient was concerned about the therapist's vulnerability. That concern might well be based on a realistic issue (Kohut's illness), but the concern is markedly enhanced by the patient's projections based on his own life experience with a sick father. Thus the present may seed a past fantasy; but it is not seen as a *real* repetition of an earlier event in the patient's life. I believe that the patient could not deal with the past and he cannot deal with the present—not because of fantasy overlays—but because the present is essentially no different than the past. He is having the same experience of mystification. What was his relationship with his sick father? Did they talk? Was his father stoical, pathetic, vicious? Did he help his father? One might wonder whether acknowledgment of the truth in the patient's perceptions of the real analyst might be necessary to the patient's cure. Even more, one might wonder, does the patient have some real concern for Kohut's sensibilities and for his health? Does he, perhaps, feel that Kohut is unwell and vulnerable? Does he wish to protect him out of a genuine caring by leaving him an effigy? Is he afraid of his rage because it is, indeed, not safe to be angry in these circumstances? As Freud himself states, "When all is said and done, it is impossible to destroy anyone in absentia or in effigy" (Freud, 1912). Why is the manifest content, the literal concrete and very specific message of the dream surface disregarded in the pursuit of something "deeper", a better reality? It is a beautiful dream, rich in imagery and literary reference. Does he know T. S. Eliot's *The Hollow Men* (Eliot, 1930) ?

> I
>
>> *We are the hollow men*
>> *We are the stuffed men*
>> *Leaning together*
>> *Headpiece filled with straw, Alas!*
>
> and later,
>
> III
>
>> *This is the dead land*
>> *This is the cactus land*
>> *Here the stone images*
>> *Are raised, here they receive*
>> *The supplication of a dead man's hand*
>> *Under the twinkle of a fading star.*

Who is the person (not patient) who dreams this dream?

There is a dimension of creative play, of pleasure taken in developing skills, and of curiosity for curiosity's sake which all metapsychological systems which emphasize developmental pathology underestimate.

The richness and variety of patients' efforts to grapple with the world, the marvelous narrative creations which take place in treatment, and the sometimes startlingly prescient observations patients unwittingly make about the therapeutic process *and* the therapist, make each treatment a novel adventure, at least for the therapist not reified by his/her metapsychology.

The goal of therapy, from this perspective, is not the restoration of the self, as Kohut would have it, but the enrichment of the self, the person becoming more present, more defined, closer to an aware personality; that is, the self comes to approximate the personality. To put it somewhat aphoristically, the patient becomes what he really is, not what he/she should be, or would like to be. All neuroses are failures of presence, warts and all. I think Sullivan's view of cure, closer to Freud's, lacks the utopian element one finds in Self psychologists and in Winnicott, whereinbad is the absence of good, not a real dimension of personality.

We are interested, then, in how the patient perceives the world, how he/she negotiates it, and what it is like for us to engage that world. As Sullivan said it, the expertise of the therapist "refers to his skill in participant observation of the unfortunate patterns of his own and the patient's living" (Sullivan, 1949). This is not "psychic reality", but a real world as valid as the therapist's and apposite to his. Where the patient's world and the therapist's world overlap, there is transference and countertransference, a contained and highly amplified area of interaction. We are helping the patient define his/her own reality in interaction with the therapist. In this perhaps radical interpersonal view, the therapist is present in a real way, bringing himself/herself to the exchange and being, in turn, effected by the patient. One is still examining the totality of the patient's experience: developmental, historical, and contemporaneous, as it is manifested in memories, dreams, fantasies, and transactional reports. In this system "What happened to the cat?"; "Why didn't you tell this patient of your office change?"; and "Could the patient be worried about the real potential of hurting you?"—questions which are only obvious after you've thought of them—become, not a preliminary to the real psychoanalysis, but the very locus of inquiry.

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